

# Health Information 2010-2011

\_\_\_\_\_

Child's Name

\_\_\_\_\_

Family Physician/phone

\_\_\_\_\_

Hospital Preferred

\_\_\_\_\_

Food Allergies

Please indicate which of the following conditions your child may have/had and the dates.

\_\_\_\_\_ Seizures

\_\_\_\_\_ Bleeding disorders

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Asthma

\_\_\_\_\_ Heart Condition

\_\_\_\_\_ Other

Are there any routine medications or treatments your child requires? If so, please list.

Are there any activities from which your child should be restricted? If so, please list.

The information I have provided by my written word in regard to my child's information and health history is accurate to the best of my knowledge.

\_\_\_\_\_

Name

\_\_\_\_\_

Date

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