HEALTH HISTORY FORM

Today's Date _______________

Child's Name ____ Date of Birth ______________________________

Address ____ Phone __________________________________

Parent's Name _______________________________________ Work Phone ______________________________

Emergency Contact Name ______________________________ Phone __________________________________

Physician Name ______________________________________ Phone __________________________________

Medical Insurance Company Name ______________________ Policy # _________________________________

A. Illnesses and Injuries (Circle all that apply)

Asthma	Diabetes	Epilepsy	Kidney Disease
Convulsions/Seizures	Ear Infection	Heart Disease	

Date of Last Health Exam ____________________ Any Medical Problems Noted? _________________

If yes, please explain ____

Since child's last exam has he/she had:

A serious illness? ____________ What? ____

An illness lasting longer than a week? ____

An operation or fracture? ____

Treatment in a hospital or emergency room? ____

Restrictions from physical activity? ____

Medication to be taken on a regular basis? ____

B. Allergies (Circle all that apply)

Animals	Medicines	Insect Stings	Food
Plants	Hay fever	Pollen	Other

Please specify if any are any circled ____

C. Immunizations

	Year primary series completed	*Year of last booster*
DPT	_________	________
Measles	_________	________
Mumps	_________	________
Oral Polio	_________	________
Rubella	_________	________
Tb Tine	_________	________
Chicken Pox	_________	________
Hib Hepatitis	_________	________

D. Other health conditions: ____

E. Permission to seek medical help: If I cannot be reached in case of emergency, the bearer of this form is authorized to act on my behalf to seek medical treatment as they deem necessary for my child.

Signature of parent/guardian ______________________________________ Date ___________________________