Shining Starr Learning Academy Summer Camp Health History

First Name	**Last Name**	Middle Name	Date of Birth
Street Address	City, State, Zip	Who student lives with	Age Gender

In case of an emergency list 2 contacts in order of who is the most available:

First Name	Last Name	Relationship	Cell Phone #

Check any if applicable:		**ALLERGIES**
Bleeding Disorders	Anxiety	Asthma
Chicken Pox	Asperger Syndrome	Hay Fever
Diabetes	Austism Spectrum	Plants/Pollen Allergy
German Measles	Developmental Delay	**Animals** - if so which ones?
Heart Disease	Dyslexia	
Kidney	Ear Infections	
Lyme	Hearing Loss	**Food** - if so what specifically?
Measles	Menstrual - started	
Mumps	OCD	
Rheumatic Fever	Vision	
Seizures	Occupational Therapy	**Insect** Bites/Stings - which ones/ reaction
Tuberculosis		
Other	Speech Therapy	
	Sensory - which ones?	**Medicine/drugs**
Any major surgeries		

This health history is complete to the best of my knowledge at the time of completion. If at any time there is a health change, I will notify the school and update the current form. By signing this form, I release Shining Starr Learning Academy from any and all loss, damage, liability and claims. I have instructed my child to follow instructions and the school rules.

Print Parent Name Signature of Parent Date Signed