Health Information Form

Childs Name _____ Age _____ Birth Date _____

Allergies_____

_____

In Case of Allergic Reaction_____

Name of Child's Doctor _____ Phone # _____

Preferred hospital (in case of emergency) _____

Previous operations/hospitalizations_____

_____

Please note any medical conditions that we should be aware of (i.e. asthma, diabetes, etc.)

_____

Physical limitations _____

Is your child currently taking any medication on a regular basis? Yes or No

Would this medication be administered at school? Yes or No

(If yes, please attach detailed instructions for administering medication & a doctors authorization.)

Is your child currently receiving special professional services? (i.e. speech therapy)

_____

_____ _____

Parent's Signature Date

_____ _____ _____

Home Phone Parent's Cell Phone Other Contact Number