

## Medical History / Information Form

*Please complete this form so staff and health providers can be aware of and best care for your child's health needs. If necessary, describe in detail any physical and/or psychological ailment, illness, susceptibility, weakness, limitation, handicap, disability, or condition to which you are subject to. **Please list any action or protection that may be required to care for your needs.***

Please circle any of the following conditions that you may have:

### ALLERGIES:

Bee Stings

Penicillin

Dairy

Poison Ivy, Oak, Sumac

Nuts

Pollen

Peanuts

Eggs

Other Drugs/Medications: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

### MEDICAL CONDITIONS:

Asthma

Hypo - glycemia

Diabetes

Motion Sickness

Eczema

Nose Bleed

Epilepsy

Upset Stomach

Fainting

Seizures

Headaches

Other: \_\_\_\_\_

Heart

\_\_\_\_\_

### SPECIAL CONDITIONS:

ADD

Fears

ADHD

ODD

Anxiety

Sleeping disorders

Bi- polar

Hearing Impairment

Glasses or Contact lenses

Physical handicap

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Does your child have any condition that might prevent him/her from participating in any particular activity?

No            Yes    (if yes, please explain) \_\_\_\_\_  
\_\_\_\_\_

For your safety please circle one of the following that best describes you:

Good swimmer

Fair swimmer

Non swimmer

Date of your child's last tetanus shot: \_\_\_\_\_ Blood type: \_\_\_\_\_

Please list any specific care your child may need in the event of a medical emergency concerning any of the previously selected conditions:

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Please list any medications and doses that your child is taking:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____