

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 your child is subject to. **Please list any action or protection that may be required to care for your child.***

Please circle any of the following conditions that your child may have:

ALLERGIES to:

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 |

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 child's safety please circle one of the following that best describes your child:

- 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:

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

_____	_____
_____	_____
_____	_____