Medical History

The phone number where I may be reached in case of emergency is:

Day: ________________________________ or ________________________________

Night: ________________________________ or ________________________________

If I cannot be reached, contact: Name ________________________________

Relationship ________________________ Phone ________________________

Name of Child's physician ________________________ Physician's phone ____________________

Health Record: Please provide the following information for use in identifying limitations on your child's activities, and providing proper health history in the event we have to take your child for medical treatment.

A. Birth date ____________________ Last Tetanus immunization ____________________

B. Must any of the following medical or physical conditions be taken into consideration when your child is thinking about performing physical activities? Please mark "Yes" or "No" in the appropriate column below, then give specific detail in the space provided.

Limitations Must Be Considered?
Yes / No

1. Epilepsy, convulsions, loss of consciousness, dizziness, paralysis .... ____________
2. Lung Disease: Asthma, pain in chest or shortness of breath .... ____________
3. Diabetic or Kidney disease .... ____________
4. Arthritis, strained, pulled or weak muscle .... ____________
5. Pregnancy .... ____________
6. Environmental allergies (especially to insects) .... ____________
7. Impaired vision or hearing .... ____________
8. Allergies to Medicine.. ____________
9. Broken bones, strained/sprained joints .... ____________

If you answered " Yes " in any of the above spaces, please describe in detail any limitations that these conditions might cause while your student is doing various outdoor, physical activities.

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Is your child currently taking medication or under the care of a physician? ____________ If so, please describe

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