Appendix G

HEALTH HISTORY FORM

DATE____________________
CHILD'S NAME____ DATE OF BIRTH____________________
ADDRESS____PHONE (____) ____________________
PARENT'S NAME____WK NO (____) ____________________
EMERGENCY CONTACT____ (____) ____________________

PHYSICIAN____ (____) ____________________

MEDICAL INSURANCE
____
POLICY #

A. ILLNESSES AND INJURIES (CHECK THOSE THAT APPLY)
_____ASTHMA _____DIABETES _____EPILEPSY _____KIDNEY DISEASE
_____CONVULSIONS/SEIZURES _____EAR INFECTION _____HEART DISEASE
DATE OF LAST HEALTH EXAM______________ANY MEDICAL PROBLEMS NOTED?
____
IF YES, PLEASE EXPLAIN
____
SINCE CHILD'S LAST EXAM HAS HE/SHE HAD:
A SERIOUS ILLNESS________WHAT?____
AN ILLNESS LASTING LONGER THAN A WEEK? ____
AN OPERATION OR FRACTURE? ____
TREATMENT IN A HOSPITAL OR EMERGENGY ROOM? ____
RESTRICTIONS FROM PHYSICAL ACTIVITY____
MEDICATION TO BE TAKEN ON A REGULAR
BASIS____

B. ALLERGIES (CHECK THOSE THAT APPLY)
______ANIMALS ______MEDICINES ______INSECT STINGS _____FOOD
______PLANTS ______HAYFEVER ______POLLEN _____OTHER
PLEASE SPECIFY IF ANY ARE CHECKED
____

C. IMMUNIZATIONS
IMMUNIZATION YEAR PRIMARY SERIES COMPLETED YEAR OF LAST BOOSTER
DPT ____________________ ____________________
MEASLES ____________________ ____________________
MUMPS ____________________ ____________________
ORAL POLIO ____________________ ____________________
RUBELLA ____________________ ____________________
TB TINE ____________________ ____________________
CHICKEN POX ____________________ ____________________
HIB HEPATITIS ____________________ ____________________

D. OTHER HEALTH CONDITIONS:
____

E. PERMISSION TO SEEK MEDICAL HELP
IF I CANNOT BE REACHED IN CASE OF EMERGENCY, THE BEARER OF THIS FORM IS AUTHORIZED TO ACT ON MY BEHALF TO SEEK MEDICAL TREATMENT AS THEY DEEM NECESSARY FOR MY CHILD ________________
SIGNATURE OF PARENT/GUARDIAN________________________________ DATE________________