Child's Name_____
Mother's Name_____
Address_____
_____
Home# (_____)_____
Work # (_____)_____ Cell # (_____)_____
Father's Name_____
Address_____
_____
Home # (_____)_____
Work # (_____)_____ Cell # (_____)_____

I give my consent for emergency medical care or treatment in the event I cannot be reached immediately.

_____ _____

Parent Signature Date Signed

Health History Information

Which of the following does your child have (or has had in the last year)?

Y/N Allergies
Y/N Disabilities
Physical
Sensory
Cognitive
Y/N Asthma
Y/N Diabetes
Y/N Heart Problems
Y/N Rheumatic Fever
Y/N Seizures
Y/N Other _____

Physicians Name _____
Address _____
Phone # (_____)_____