

**Health History/ General Information: Page 1**

Childs Full Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ School: \_\_\_\_\_

Address: \_\_\_\_\_

Mother's full name: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

Father's full name: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

**Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance enter "none" above.**

Alternate Emergency Contact: (in case parents cannot be reached)

Alternate contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

Alternate contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

**Health History:**

Known allergies to Medications, Food, Plants, Insect bites or stings: (list reaction)

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Please list any medical concerns or health history that you feel we should know about your child:

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