

Effective dates: \_\_\_\_\_ to \_\_\_\_\_

**Please print in ink**

Name: \_\_\_\_\_ Age \_\_\_\_\_ Birthday \_\_\_\_\_  
LAST FIRST MIDDLE

Year in school \_\_\_\_\_  Male  Female Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Pager / cell \_\_\_\_\_

Medical insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

Mother's name \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Father's name \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Physician \_\_\_\_\_ Office phone \_\_\_\_\_

Dentist \_\_\_\_\_ Office phone \_\_\_\_\_

### Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

**Check the following areas of concern for this student. If necessary, add another page with details:**

- For your child's safety and our knowledge, is your student a—  
 good swimmer       fair swimmer       non-swimmer
- Does your child have allergies to—  
 pollens       medications       food       insect bites
- Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:  
 asthma       epilepsy / seizure disorder       heart trouble       diabetes  
 frequently upset stomach       physical handicap
- Date of last tetanus shot: \_\_\_\_\_
- Does your child wear       glasses       contact lenses
- Please list and explain any major illnesses the child experienced during the last year:

Additional comments:

Should this child's activities be restricted for any reason? Please explain: