



Health Form

Child's Name _____ Date of Birth ____ / ____ / ____

Age ____ Sex ____ Name of School _____ Grade ____

Home phone# _____ Cell phone# _____

Parent or Guardian _____

Home Address _____

Place of Business _____ Business phone _____

Business Address _____

If not available in case of emergency, please contact:

Name _____	Phone Number _____	Relationship _____
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Family Physician _____ Phone # _____

Physician address _____

Please answer the following questions and explain any "yes" answers.

1. Will your child be under medical treatment for any condition(s) during this program?

No _____ Yes _____

2. Does your child have any chronic illnesses? No _____
 Yes _____

3. Should there be any restrictions on your child's activities? No _____
 Yes _____

4. Has your child had Chicken Pox? No _____ Yes _____

5. Please note any additional information or suggestions regarding your child which may be helpful _____

6. When did your child receive his/her last TETANUS Shot? _____
