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_____