

PARTICIPANT'S NAME _____

HEALTH HISTORY

The health history is to be completed and signed by a parent/guardian.

PART I: Illness and Injuries (check those that apply)

Chronic or recurring illness: _____ Date of your child's last examination _____

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Musculoskeletal Disorders | <input type="checkbox"/> Heart Disease/Defect |
| <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Other (specify) _____ |

- Yes No
- Were any complicating medical problems noticed in your child's last examination?
- Is your child currently under a physician's care for a medial problem?

- Since your child's last health exam
- a serious injury requiring medical attention?
- an illness lasting more than five days?
- a surgical operation or fracture?
- medication prescribed by a physician to be taken on a regular basis?
- treatment in a hospital as an in-patient or in the emergency room?
- any restrictions concerning physical activities?

Please explain any "Yes" answers to the above questions. Include dates: _____

If your child has not had a health examination in the previous two years/24 months, or if you have indicated a "Yes" reply to any of the above questions, a written statement from your child's physician granting permission to participate in strenuous activity.

PART II: Allergies (Check those that apply. Specify causal agent and nature of reaction – e.g. penicillin causes hives)

- | | |
|--|---|
| <input type="checkbox"/> Animals _____ | <input type="checkbox"/> Medicine/Drugs _____ |
| <input type="checkbox"/> Food _____ | <input type="checkbox"/> Plants _____ |
| <input type="checkbox"/> Hayfever _____ | <input type="checkbox"/> Pollen _____ |
| <input type="checkbox"/> Insect Stings _____ | <input type="checkbox"/> Other _____ |

What action should be taken? _____

PART III: Other health conditions (check those that apply)

- | | |
|---|--|
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> Wears Contact Lenses/Glasses | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Special Dietary Regiment | <input type="checkbox"/> Other (specify) _____ |

Please explain. Indicate any information useful to the adult in charge in relation to any of the above health conditions. Indicate any activity to be encouraged or restricted.

PART IV: Immunization History

Year Primary Series Completed

Year of Last Booster

PART IV: Immunization History	Year Primary Series Completed	Year of Last Booster
D.T.P.	_____	_____
<i>Diphtheria</i>	_____	_____
<i>Pertussis</i> (whooping cough)	_____	_____
<i>Tetanus</i> (within 10 years)	_____	_____
Td (tetanus/diphtheria)	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella (German Measles)	_____	_____
Oral Polio	_____	_____
Hib (Haemophilus influenza B)	_____	_____
Hepatitis B	_____	_____
Tuberculin Test (most recent)	_____	_____
Other	_____	_____

Please include a copy of your insurance card (both sides).