

Health Form & Questionnaire

Youth's Name _____ Birth date _____ Age _____
Address _____

Phone _____ Cell Phone _____

In case of emergency contact

Phone (_____) _____

Health History

Allergies

Food _____

Medicine _____

Other _____

Health Problems

List Medication(s) child is taking

Give directions if nurse is to administer the medicine (storage, times to be given, and how it is to be given, etc.)

Immunizations

Date of last Tetanus shot _____

Permission for staff to provide over-the-counter medication (Tylenol, Sudafed, Cough drops, etc.) to your child according to directions listed on medication as needed. Yes No

In case of an emergency, you the parent/guardian authorize the necessary care/treatment of (child's name) _____ that is deemed necessary by authorized medical authorities.

Signature _____ Date _____