

Health History for Jr. & Sr. High Youth

Name: _____ Date of Birth: _____

To protect your child from possible embarrassment, but not to exclude him/her from the program, the following information is requested. Check and give approximate dates, if possible.

General:

Frequent Ear Infections _____
Hear Defect/Disease _____
Convulsions _____
Diabetes _____
Bleeding/Clotting Disorders _____
Bed Wetting _____
Sleep Walking _____
Operations or Serious Injuries _____

Hay Fever _____
Insect Stings _____
Penicillin _____
Other Drugs (List) _____

Diseases:

Chicken Pox _____
Measles _____
German Measles _____
Mumps _____
Asthma _____

1. Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity? Yes ____ No ____ . If Yes, explain:

2. Please give is the name and phone number of your child's regular physician:

3. In the event of a minor illness (such as cold or headache), do you authorize the Leadership of Calvary Chapel of Fullerton to give your child common remedies such as Tylenol, cough medicine, etc., in dosages appropriate for his/her age? Yes ____ No ____ . Please list any specific instructions:

4. Please list any medications that you child will need to have on any camps or overnight youth events:

MEDICATION:

DOSAGE:

WHEN TAKEN:

Insurance Information

Insurance Company Name: _____

Policy Number: _____

Insurance Company Address: _____

Insurance Company Phone: _____