# HEALTH INFORMATION

Child's Name _____

Child's Physician: _____ Phone #: _____

Child's Dentist: _____ Phone #: _____

**Please check if your child has had any of the following and list date:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Arthritis | | Chicken Pox | | Heart Disorder | | Pneumonia | | Speech Problems |
| | Asthma | | Diabetes | | Hepatitis | | Rheumatic Fever | | Tonsillitis |
| | Blood Disorder | | Ear Conditions | | History of PKU | | Scoliosis | | Tuberculosis |
| | Blood Transfusion | | Ear Tubes | | Kidney Problems | | Seizure | | Vision Problems |
| | Braces/Capped Teeth | | Head Injuries/Concussion | | Migraines | | Skin Conditions | | |

Allergies _____ Symptoms _____

Insect/Bee Allergy _____ Reaction _____

Medication _____

Surgery _____

Other illnesses or serious injuries _____

Physical Limitations _____

Is your child under the care of a physician for a health problem now? _____
Condition _____

Date of last physical exam _____

Is your child currently taking any medication? _____ Medication _____