PARENT HEALTH FORM

Child's Name		Gender	Birthdate:
Father		Address	
Father Home Phone	Father Work Phone		Father Cell Phone
Mother (Maiden Name)		Mother Present Name	
Address			
Mother Home Phone	Mother Work Phone		Mother Cell Phone
Physician	Phone		Physician Address

PLEASE LIST ANY ON-GOING MEDICAL PROBLEMS YOUR CHILD HAS: ____

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ILLNESS & CONDITIONS THE CHILD HAS HAD OR HAS PRESENTLY (GIVE DETAILS)

Anemia	Heart Disease	Rheumatic Fever
Chicken Pox	Ear Infections	Frequent Colds
German Measles (Rubella)	Speech Problems	Frequent Sore Throat
Measles	Swallowing Problems	Eye Problems
Scarlet Fever	Asthma	Seizures
Mumps	Diabetes	Wears Glasses
Pneumonia	Contact w/ Tuberculosis	Other:

SERIOUS ACCIDENTS, OPERATIONS, OTHER ILLNESSES, X-RAYS, HANDICAP, ETC. (Give details): ______________________

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MEDICATIONS YOUR CHILD TAKES ON A DAILY BASIS: ____

IN THE EVENT THAT A PARENT/GUARDIAN CANNOT BE REACHED, PLEASE LIST TWO PEOPLE WHO COULD BE CALLED TO PICK UP YOUR CHILD IN CASE OF ILLNESS OR EMERGENCY:

NAME: _____________________________ **RELATIONSHIP TO STUDENT:** _______________**PHONE NUMBER:**___________

NAME: _____________________________ **RELATIONSHIP TO STUDENT:** _______________**PHONE NUMBER:**___________

IN CASE OF EMERGENCY, I GIVE PERMISSION TO CALL THE DOCTOR OR DENTIST LISTED BELOW:

PHYSICIAN: ____ **PHONE NUMBER:** ________________________

DENTIST: ____ **PHONE NUMBER:** ________________________

HOSPITAL PREFERENCE: ____

PARENT/GUARDIAN SIGNATURE: ____ **DATE:** _________________