

## 2016-2017 Busy Hands Health History Form

*This information is confidential to the Director of Recreation & the Program Instructor, unless needed for medical reference.*

**Child's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Program (3 yr. or 4 yr.):** \_\_\_\_\_

**Parent E-Mail Address:** \_\_\_\_\_

**Phone # (during Busy Hands hours):** \_\_\_\_\_

1. Is the child allergic to:

Bee stings	Y	N
Insect Bites	Y	N
Penicillin	Y	N
Aspirin	Y	N
Poison Ivy	Y	N

Particular Foods (please list):  
\_\_\_\_\_

Other Medications (please list):  
\_\_\_\_\_

2. Has the child had/or is subject to:

Epilepsy	Y	N
Heart Trouble	Y	N
Convulsions	Y	N
Fainting Spells	Y	N
Asthma/Wheezing	Y	N
Fractures or dislocations	Y	N
Frequent Stomach	Y	N

Other Serious Illness (please list):  
\_\_\_\_\_

3. Is the child under medical care for any illness?      Y      N

What medication (if any) is the child currently taking? \_\_\_\_\_

4. Has the child been immunized against:

M.M.R.(measles,mumps,rubella)	Y	N
D.P.T.(diphtheria,pertussis,tetanus)	Y	N
Polio	Y	N
Hepatitis B	Y	N
Varicella (chickenpox)	Y	N

Date of last Tetanus Booster \_\_\_\_\_

5. Does the child wear eyeglasses or contact lenses?      Y      N

6. Should the child's activities be restricted in any way?      Y      N

Please list: \_\_\_\_\_

**Name of Child's Doctor:** \_\_\_\_\_

**Doctor's Phone #:** \_\_\_\_\_