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.(diptheria,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 #: _____**