Health History – Parent's Report

To be completed, signed by parent/guardian and updated annually

CHILD'S NAME SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNERS NAME	DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME	DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS/HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?	DATE OF LAST PHYSICAL/MEDICAL EXAMINATION
NAME OF PHYSICIAN	FAMILY MEDICAL HOSPITAL
INSURANCE CARRIER	GROUP # MEMBER #

Past Illness – Check illnesses that child has had and specify approximate dates of illnesses:	**Dates**		**Dates**		**Dates**
☐Chicken Pox		☐Diabetes		☐Poliomyelitis	
☐Asthma		☐Epilepsy		☐Ten-Day Measles (Rubeola)	
☐Rheumatic Fever		☐Whooping cough		☐Three-Day Measles (Rubella)	
☐Hay Fever		☐Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS	
DOES CHILD HAVE FREQUENT COLDS?	HOW MANY IN LAST YEAR?

LIST ANY ALLERGIES WE SHOULD BE AWARE OF
PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR	DOES CHILD TAKE PRESCRIBED MEDICATION?	IF YES, WHAT KIND AND ANY SIDE EFFECTS
DOES CHILD USE ANY SPECIAL DEVICE(S):		IF YES, WHAT KIND:	

Vaccine	4-6 Years Old Elementary School at Transitional-Kindergarten/Kindergarten and Above	7-17 Years Old Elementary or Secondary School	7th Grade*
Diphtheria, Tetanus, and Pertussis	5 doses of DTaP, DTP, or DT (4 doses OK if one was given on or after 4th birthday) Parent Initial _______________	4 doses of DTaP, DTP, DT, Tdap, or Td (3 doses OK if last dose was given on or after 2nd birthday. At least one dose must be Tdap or DTaP/DTP given on or after 7th birthday for all 7th-12th graders.) Parent Initial __________	1 dose of Tdap (Or DTP/DTaP given on or after the 7th birthday.) Parent Initial _________
Measles, Mumps, and Rubella (MMR or MMR-V)	2 doses (Both given on or after 1st birthday. Only one dose of mumps and rubella vaccines are required if given separately.) Parent Initial ____________	1 dose (Dose given on or after 1st birthday. Mumps vaccine is not required if given separately.) Parent Initial _________	2 doses of MMR or any measles-containing vaccine (Both doses given on or after 1st birthday.) Parent Initial __________
Hepatitis B (Hep B or HBV)	3 doses Parent Initial ___________		
Varicella (chickenpox, VAR, MMR-V, or VZV)	1 dose Parent Initial ___________	1 dose for ages 7-12 years. 2 doses for ages 13-17 years. Parent Initial _________	

CONSENT FOR EMERGENCY MEDICAL TREATMENT

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO ____ (LEADER OR CO-LEADER) TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR ________________________________ (NAME). THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE WORK PHONE