

Health Form 2008 - 2009

(Completion required for final registration)

PLEASE RETURN FORM AT REGISTRATION:

NAME _____ DATE OF BIRTH _____

ADDRESS _____ FEMALE _____ MALE _____

_____ DIOCESE CHARLOTTE

Is this participant in general good health and able to participate in all normal activities?
YES _____ NO _____ (If not, please submit a statement indicating limitations.)

Please give date of most recent physical examination.

DATE: _____

FAMILY PHYSICIAN(S) OR CLINIC: _____

ADDRESS _____ PHONE _____

Immunization History

GIVE DATES PLEASE:

DPT _____ DPT BOOSTER _____ TETANUS BOOSTER _____

POLIO SERIES _____ POLIO BOOSTER _____

Allergies (Please write yes or no next to each)

HAY FEVER _____ ASTHMA _____ SULFA _____

FAINING _____ POISON IVY _____ OTHER _____

CONVULSIONS _____ PENICILLIN _____

BEE STING _____ OTHER _____

List Current Medications being taken and Current Medical Condition:

If any of the above are yes, please submit a statement of how the child has been treated and with what medication. Submit a statement of any other medications currently in use and what for. This and any other medication will be dispensed by the Director of the program.

Operations or Serious Injury _____

Dates _____

Please notify the office if this child is exposed to any communicable disease during the three weeks prior to program attendance.

In signing this application, I hereby certify that the above information is correct and give permission for my child to be transported in privately owned vehicles to and from public transportation or for approved out-of-program activities; and for the release of medical records to an attending physician in case of illness. In case of medical emergency, I understand that every effort will be made to contact parents or guardian of participants. In the event that I cannot be reached, I hereby give permission to the physician selected by the Program Director to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child, as named herein.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE _____

Telephone During Program: _____ Alternate Phone # _____

Family Health Insurance Co.: _____ Policy # _____