

# Health Form

Name:

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Date of birth:

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Pediatricians Name and Phone Number:

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Is your child allergic to:  Bee stings  Insect Bites  Poison Ivy  
 Particular Foods  Particular Medication  Other Please specify:

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Has your child had or been subject to:  Seizures  Heart Trouble  Convulsions  
 Fainting Spells  Asthma  Diabetes  Other Please specify:

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Is your child on medication:  Yes  No  
Medication Name and Dosage:

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Is your child under medical care for any illness or health problems?  Yes  No  
If yes, please specify:

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Should your child's activities be restricted in any way?  Yes  No  
If yes, please specify:

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Person to contact in case of emergency (please include phone number)

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Note: All participating children should be accompanied by their parents; this form is filled in case that parents send their child under the supervision of a friend or another family member.