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### HEALTH FORM (Page 1 of 2 Pages)

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**MEDICAL INSURANCE:**

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Health Insurance Provider: \_\_\_\_\_

Child's Medical Subscriber #: \_\_\_\_\_ Group # \_\_\_\_\_

My child has the following allergies:

| ALLERGY | REACTION | TREATMENT |
|---------|----------|-----------|
|         |          |           |
|         |          |           |
|         |          |           |

My child has the following drug sensitivities:

| ALLERGY | REACTION | TREATMENT |
|---------|----------|-----------|
|         |          |           |
|         |          |           |
|         |          |           |

My child has the following medical conditions (ie: asthma):

|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

PARENT/GUARDIAN NAME (Please Print): \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_