

HEALTH HISTORY

(PLEASE DO NOT ALTER ANY INFORMATION ON THIS FORM)

Name _____ Date of Birth: ____/____/____

Family Physician _____ Phone ____ - _____

Name of Insurance Company _____

Address of Insurance Company _____

Name on Policy _____

Policy Number _____

Is your child affected by or allergic to the following?

Latex _____ Hay Fever _____ Poison Ivy _____ Hearing _____

Nose Bleeds _____ Ear Infection _____ Asthma _____ Peanuts _____

Contact Lens _____

Foods (explain) _____ Medications (explain) _____

Is your child restricted from participating in any physical education activity?

Yes (explain) _____ No _____

Please indicate your preference and normal dosage used at home for simple headaches, allergies etc.

Tylenol _____ Motrin _____ Benadryl _____ Sudafed _____ Other _____

****Must read and sign in both locations below****

This Health History is correct to the best of my knowledge and my child has permission to engage in all activities except as noted above by me.

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

PARENT AUTHORIZATION FOR MEDICAL EMERGENCY TREATMENT:

In case of Medical Emergency, I understand every effort will be made to contact parents or guardian of _____. In the event I cannot be reached, I hereby give permission to the physician selected by authorized Bishop Hodur Retreat Center personnel to hospitalize, secure proper treatment for, and to order the injection, anesthesia or surgery for my child named above.

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

**** Please include a copy of your insurance card front and back****