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****