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****