

Part Two --- Health Information

Basic Health History:

- | | | | |
|--|--------------------------------------|---|--|
| <input type="checkbox"/> frequent ear infections | <input type="checkbox"/> asthma | <input type="checkbox"/> bleeding disorders | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> heart defect | <input type="checkbox"/> convulsions | <input type="checkbox"/> epilepsy | <input type="checkbox"/> hyperactivity |
| <input type="checkbox"/> hypertension | <input type="checkbox"/> bedwetting | <input type="checkbox"/> sleepwalking | |

Allergies:

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> penicillin | <input type="checkbox"/> serious poison ivy | <input type="checkbox"/> bee stings |
| <input type="checkbox"/> hay fever | <input type="checkbox"/> food allergies | <input type="checkbox"/> aspirin |
| <input type="checkbox"/> other (specify): | | |

Immunizations: All immunizations must be up to date. Indicated dates of basic immunization or most recent booster.

_____ DPT _____ Polio _____ Measles

_____ Current Tetanus (If date cannot be supplied, please initial this statement: "In case of an emergency, the attending physician may administer a tetanus booster." _____)

Operations, Serious or Chronic Illnesses:

Dietary Modifications While At Institute:

Prescription Drugs Student brings to Institute:
(include instructions)

Part Three --- Health Examination Record

This health history record is correct so far as I know, and the person herein described has permission to engage in all prescribed Institute activities except as noted by me.

Physical Restrictions: _____ Date of Last Physical _____

Parent's Signature _____ Date _____

Name & Phone # of Family Physician _____ () _____