

First Lutheran Children's Programs Health History Form

This information on this form is not part of the child's or staff acceptance process, but is gathered to assist us in identifying appropriate care.

Date _____

Child's Name: _____

Gender: _____ Male _____ Female Birth date ___/___/___ Age _____

Home Address: _____

Custodial parent/guardian: _____

Home Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Second parent/guardian or emergency contact: _____

Home Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

If not available in an emergency, notify:

Name _____

Relationship _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Insurance Information

Is the participant covered by family medical/hospital insurance? _____ no _____ yes

If so, indicate carrier or plan name _____ Group # _____

Social security # of policy holder or insurance ID number _____

Hospital Preference: _____

Parent/Guardian Authorization: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all program activities except as noted.

I hereby give permission to the medical personnel selected by the program director to order routine test, x-rays, treatment; to release any records necessary for insurance purposes; and provide or arrange necessary related transportation for me/or my children. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the director to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent or guardian: _____

Printed Name: _____

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Child's Name: _____

Date: _____

Allergies (list all known)

Describe reaction and management of the reaction

Medication allergies (list)

Food allergies (list)

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

MEDICATION BEING TAKEN

Please list all medication. Medication must be in the original packaging/bottle that identifies the prescribing physician, the name of the medication, dosage and the frequency of administration. Over the counter medicines will be administered only with a doctor's note with the same information listed for prescriptions.

This person takes medications as follows:	
Med.#1 _____	Dosage _____ specific time of day _____
Med.#2 _____	Dosage _____ specific time of day _____

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Child's Name: _____

Date: _____

Restrictions

The following restrictions apply to this individual.

Dietary Restrictions _____

Explain any restrictions to activities (e.g. what can not be done, what adaptation or limitation are necessary)

GENERAL Questions (Explain "yes" answers below)

Has/does the participant: Yes No

- | | | |
|---|----------|----------|
| 1. Had any recent injury, illness or infectious disease? | Y | N |
| 2. Have a chronic or recurring illness/condition? | Y | N |
| 3. Ever been hospitalized? | Y | N |
| 4. Ever had surgery? | Y | N |
| 5. Have frequent headaches? | Y | N |
| 6. Ever had a head injury? | Y | N |
| 7. Ever been knocked out? | Y | N |
| 8. Wear glasses, contacts or protective eyewear? | Y | N |
| 9. Ever had frequent ear infections? | Y | N |
| 10. Ever had seizures? | Y | N |
| 11. Ever diagnosed with a heart murmur? | Y | N |
| 12. Have asthma? | Y | N |
| 13. Have diabetes? | Y | N |
| 14. Ever had emotional difficulties? | Y | N |
| for which professional help was sought? | Y | N |
| 15. Have any skin problems? | Y | N |

Please explain any "yes" answers, noting the number of the question.

Which of the following has the participant had? Please circle

Measles Mumps German Measles
Chicken Pox Hepatitis

TB Mantoux Test Results: _____Positive _____Negative

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Child's Name: _____

Date: _____

Please give dates of immunizations for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____
TD		_____	_____	_____	_____
Tetanus		_____	_____	_____	_____
Polio		_____	_____	_____	_____
MMR		_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____
Varicella		_____	_____	_____	_____
BCG		_____	_____	_____	_____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the program should be aware.

Name of Family Physician _____ **Phone** _____

Address: _____

Name of family dentist/orthodontist _____ **Phone** _____

Address _____