



Children's **Enrichment** Center
at First-Centenary United Methodist Church

Medical History Form 2025/2026

Please print all information

Child's full name (first, middle, last):

Child's birthdate _____

Home address: _____

Phone:(home) _____

Father (w) _____ mother (w) _____

Father cell _____ Mother cell _____

email address (1) _____

email address (2) _____

Any additional contacts _____

I hereby authorize the Children's Enrichment Center staff to give any and all necessary emergency medical/dental care for my child _____ while said child is in the Children's Enrichment Center's care. I understand that the Children's Enrichment Center is not liable for any emergency care administered to my child. If necessary, the following insurance information may be given:

Insured company _____

Insured's name _____

Policy # _____

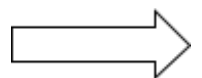
Group# _____

Insurance through (company name) _____

telephone # _____

Parent Name (please print) _____

Parent Signature _____ **date** _____



Child's Name(please print)_____

Does your child have or has your child ever been treated for any of the following conditions? If yes, please Circle those, which apply:

Allergies	Skin Irritations	Eczema
Heart trouble	Acid Reflux	Seizures
Digestive problems	headaches	respiratory Problems
Ear Infection	Sinus Infection	

Does your child have a diagnosis of an allergy from a healthcare provider: YES NO

What is the current diagnosis from the healthcare provider_____

Name and telephone number of healthcare provider that made the diagnosis_____

How many times has your child had a reaction? NEVER ONCE MORE THAN ONCE

Does your child have any food allergies? YES NO If yes, to what foods?_____

How quickly do symptoms appear after exposure to food(s)?_____

What are the early signs and symptoms of your child's allergic reaction? (please be specific)_____

****If YES to above you must provide updated physician note annually to keep in your child's file****
(fax 423-756-8589)

Does your child take medication for this allergy?_____What?_____

If yes for allergy medication, do you keep the medication at CEC?_____

Does your child have Seasonal/Insect/Environmental allergies? YES NO

If yes, how does your child react?_____Does your child have medication for these allergies? YES NO If yes, what is the medication?_____

If yes how are allergies treated at home?_____

Has your child ever had convulsions? YES NO

If yes, please explain:_____

Has your child ever had an asthma attack? YES NO

If yes, please explain:_____

If yes, do you keep an inhaler at the Children's Enrichment Center?YES NO

****If your child has any kind of allergic reaction may we have your permission to administer children's Benadryl****

YES

NO

Parent Name (please print)_____

Parent Signature_____date_____

Child's Name (please print) _____

Please provide any other pertinent health information about your child

Please provide any and all medications (prescription/over-the-counter) that CANNOT be given to your child and please explain?

Physician's name _____ address: _____ phone _____
Dentist's name _____ address: _____ phone _____

Other health professionals that your child has seen regularly (allergist, internist, etc.)

In the event of a medical emergency where a child must be transported to the hospital your child will be taken to Children's Hospital at Erlanger unless you request another medical facility and if so please give information _____

Emergency phone numbers, in the event we are unable to reach parents

First contact: Name _____ relationship _____ phone _____
Second contact: Name _____ relationship _____ phone _____
Third contact: Name _____ relationship _____ phone _____

Parent Name (please print) _____

Parent Signature _____ date _____



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