HEALTH HISTORY FORM

STUDENT Name _____

PARENT Names _____

Home Phone _____ Work Phone _____ Cell Phone _____

IN CASE OF EMERGENCY, IF PARENT CANNOT BE REACHED, CONTACT:

1. _____ _____ _____
NAME DAY PHONE CELL PHONE

2. _____ _____ _____
NAME DAY PHONE CELL PHONE

Name of Child's Doctor _____ Doctor's PHONE _____

Name of Child's Dentist _____ Dentist's PHONE _____

The following information will be released to the staff of Clocktower Players, as well as any emergency medical personnel, so that any necessary and/or appropriate accommodations can be made to ensure the safety of your child and enable him to successfully participate in CLOCKTOWER PLAYERS.

Please indicate health problems that may require any accommodations:

__ speech impairment ___visual impairment ___hearing impairment __neurological impairment

__ behavioral/emotional disorder __anxiety disorder____ seizure disorder ___bleeding/clotting disorder

____cardiac condition __learning disability _____ diabetes ____other (specify)_____

Allergies:
____ food (specify) _____
____ penicillin
____ insect bites or stings
____ medication (specify) _____
____ asthma

If your child has asthma does he/she have an inhaler or other medication that should be administered?
If so, please include a separate letter with name and dosage as well as conditions under which it should be administered.

If your child will be taking medication while at CLOCKTOWER PLAYERS please include a separate letter with name and dosage, as well as conditions and/or times under which it should be administered.

Does your child have any chronic or recurring illness we should be aware of ? _____

Any specific activities to be limited or encouraged by physician's advice? _____

_____

Any dietary restrictions? _____Yes _____ No

If Yes, please specify: _____