Health and Medical Records

Please print or type information

Participants Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

In Case of Emergency, Notify:

Name:_____Relationship:_____

Home Phone: _____ Cell Phone: _____

Email: _____

MEDICAL HISTORY

Medical Diagnosis:
Leave blank if child has no chronic or acute medical or behavior problems.

_____

Please CIRCLE any of the following which your child had or currently has.

Sinus trouble	Asthma	Fainting Spells
Rheumatic Fever	Ear Infection	Diabetes
Kidney Disease	Heart Trouble	Frequent Diarrhea
Epilepsy	Tuberculosis	Hay Fever
Severe Stomach Pain	Menstrual Pain	Bee Sting Reaction

Allergies/Reactions/Treatments:
Please list any allergies, the type of reaction, and the treatment.
Example: allergic to bee stings, gets hives, administer epi-pen
If your child has severe life-threatening reactions, please include an epi-pen, or other treatments that your physician has recommended

_____

_____

Other allergies or reaction to medications, please specify:

_____

Please provide the following information (CIRCLE):
If yes, specify and show date below.

Do you tired easily? .....Yes / No
Do you get out of breath easily? .....Yes / No
Have you had a brief minor illness or injury during the past year? .....Yes / No
Do you have a condition now requiring regular medication or treatment? .....Yes / No
Do you have any restriction of activity for medical reason?.....Yes / No
Are you currently taking any medication prescribed by a doctor? .....Yes / No
Are there behavior considerations which need to be considered? .....Yes / No
Have you had any operation or serious injuries? .....Yes / No
Are there any special health considerations? .....Yes / No
Please Specify: _____

_____

Please provide immunization record and date of last inoculation:

Smallpox		Diphtheria		Rubella	
Tetanus		Typhoid		Mumps	
Measles		Chicken Pox		Other	
Whooping Cough		Polio Myelitis			

MEDICATIONS

Medications taken on a daily basis:
Please include specific times medication is to be given and indicate any special instructions.
For example: give with food

_____

Medications taken on an *as needed basis:*
For example: 240 mg Tylenol for headache

_____

Medications that your child will be bringing to The Holley Family Village:
(Please send medication in original labeled prescription bottle if it is a prescription medication, or in original container if it is an over the counter medication)

_____

The Holley Family Village will have a small quantity of the following over the counter medications available for participants- to be administered by medical staff. Please indicate whether or not your child may be given these medications and whether or not you would like to be called prior to child receiving medication. If parents do not indicate specific dose, then dose will be based on American Academy of Pediatric guidelines, which is based on weight, so child's approximate weight must be included.

Approximate Weight: _____

Okay to Give	Call First		
_____	_____	1.	Tylenol (acetaminophen)-headache, minor aches and pains, bumps, and minor trauma.
_____	_____	2.	Tums, Rolaids, emertrol-upset Stomach/nausea, diarrhea.
_____	_____	3.	Sudafed, Dimetapp-decongestant for mild nasal congestion.

Parent or Guardian's Signature: _____ Date: _____