COMMUNiTY LiFESTYLE

Community Lifestyle Health Form

Child's Name _____

AGE _____ **Date of Birth:** _____ **Gender**: **Male** **Female**

Health History (Please list approx. dates)

Ear Infections: _____ Rheumatic Fever: _____
Convulsions: _____ Diabetes: _____
Chicken Pox: _____ Measles: _____
German Measles: _____ Mumps: _____
Asthma:_____ Other: _____

1. Is your child under any medical/physical restrictions? If yes, please explain:

_____
_____

2. Is your child taking any medication? If yes, please explain:

_____
_____

3. Has your child been under a doctor's care or hospitalized within the last three years? If yes, please explain:

_____
_____

4. Is your child allergic to any medications/foods/insect stings? If yes, please explain:

_____
_____

Does your child have an EpiPen? Circle one: **YES** **NO** *(If yes, Community Lifestyle must be provided with it)*

5. Does your child have any behavioral conditions? If yes, please explain:

_____
_____

Family Doctor Name: _____ Phone #_____
Address: _____

As a parent/guardian of the above participating child, I certify that he/she is in good physical health, has no special needs and may participate in all of the activities of the Center's program, except as noted above:

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____