Medical History Form

Child's Name:_____

Date of Birth:_____ Sex: Male Female

A copy of the child's immunization records must be provided.

Please list dates if applicable

Measles:_____ German Measles:_____
Mumps:_____ Chicken Pox:_____
Whooping Cough:_____ Contracted Tuberculosis:_____

Medical History and Special Needs

Frequent Ear Infections:_____ Frequent Throat Infections:_____

Frequent Colds:_____ Sunburn Sensitivity:_____

Diabetes:_____ Seizures:_____

Allergies:_____ Routine Medications:_____
(If yes, please complete section below)

Disabilities:_____ Dietary Restrictions:_____
(A doctor's note must be provided)

Other:_____

Routine Medication(s):_____

Frequency & Dosage:_____

Medical Condition:_____