

Health History

Medical Information:

Child's Name _____

Name of Child's Primary Physician: _____

Phone Number: _____

Address: _____

List any: Allergies (*Medications, food, or insect stings*), physical conditions, medications needed, or diet restrictions for your child. Attach additional sheets if necessary.

List Any: Recent or current illness/ injury / existing medical conditions:

Has your child potentially been exposed to any communicable disease or have been potentially exposed to communicable disease from recent travel two weeks prior to start of TAFFY?

Circle one, if yes explain further.

Yes No

In the event that it becomes necessary, may sunscreen be applied to your child? (Circle one) Yes No

List any other concerns .

ALL Registrations will require an updated record of immunization history.

An up to date immunization record is required in order to process your child's registration into the program.

Parent/Guardian Signature: _____