



**HEALTH RECORD** (To be completed by the parent or guardian)

*This confidential health record will only be used to ensure the safety of the children in this program. This information will not be shared outside of this afterschool program. Feel free to continue your notes on back of this form.*

<b>Student's Name:</b>	<b>Date of Birth:</b>
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**1 . Please provide your child's medical history.**

CONDITION	YES (if yes, write approx. date)	NO
Asthma	<input type="checkbox"/> _____	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/> _____	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> _____	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/> _____	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/> _____	<input type="checkbox"/>
Measles	<input type="checkbox"/> _____	<input type="checkbox"/>
German Measles	<input type="checkbox"/> _____	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/> _____	<input type="checkbox"/>
Mumps	<input type="checkbox"/> _____	<input type="checkbox"/>
Corrective Device (glasses, hearing aid, etc.)	<input type="checkbox"/> _____	<input type="checkbox"/>
Does your child use an inhaler?	<input type="checkbox"/> _____	<input type="checkbox"/>

ALLERGY	YES	NO
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Insect Stings	<input type="checkbox"/>	<input type="checkbox"/>
Foods	<input type="checkbox"/>	<input type="checkbox"/>
Plants	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Topical ointments	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
If "yes" to any of the above, please specify allergy and describe reaction.		

**2 . List significant illnesses or surgeries. Provide the date and any instructions.**


**3 . Special situations or needs that program staff should be aware of:**

<input type="checkbox"/>	Child has behavioral/emotional difficulties
<input type="checkbox"/>	Child has physical disabilities
<input type="checkbox"/>	Other (describe)

**4 . Special Health Care Needs**

Does your child have special health care needs that require treatment and/or medication?  YES  NO

If yes, describe below. If your child requires treatment and/or medication during after-school hours, complete the *Health Care Plan for a Child with Special Health Care Needs* form.

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**5 . Medication**

Does your child take medication for any condition or illness?  YES  NO If yes, describe below.

If your child requires medication during after-school hours, complete the *Medication Consent* form.

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**6 . Sunscreen and Topical Ointments**

Do you give permission to the after-school program to apply sunscreen or other over-the-counter topical ointments on your child?  YES  NO

**7 . Activities to be encouraged:**

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**8 . Activities your child cannot participate in:**

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**9 . My child may participate in all program activities, except those noted in number 8 above.**

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**Parent/Guardian Signature**

**Date**