St. James C.C.D. Mondays 6pm-7:30pm
2016-2017 Health Form

TO BE COMPLETED ANNUALLY FOR EACH CHILD AND RETURNED WITH REGISTRATION FORMS

Child's Name_____

landline phone_____Birth Date_____Grade____

Father's Name_____cell phone_____

Mother's Name_____ cell phone_____

primary email: _____

Neighbors/Relative to contact in case of emergency:

1. Name_____Phone/area code_____
2. Name_____Phone/area code_____

PARENT PERMISSION TO PROVIDE EMERGENCY PHYSICIAN AND HOSPITAL TREATMENT:

If neither parent can be reached, you may have my permission to call Dr._____ at _(_____)_____. If unable to contact parents or family physician, you have my permission to transport my child to the nearest medical facility or Palos Community Hospital. We agree to assume all responsibility and expenses, including transportation, incurred by the handling of this emergency case.

YES_____ NO_____

DATE_____Parent's Signature_____

CURRENT HEALTH STATUS

Check any that apply. Give explanation if necessary.

Allergies____ Type of allergy_____
Asthma_____ ADH/ADHD _____
Diabetes_____
Epilepsy/Seizure Disorder_____
Headaches_____
Heart Condition_____
Orthopedic/Physical Limitations_____
Dental Problems_____Wears braces?_____
Digestive Problems_____
Hearing Problems_____Type of problem_____
Wears Glasses?_____Wears contacts?_____
Takes medication?_____Type of medication_____
Reason for Medication_____
Recent serious illness, injury or other health problem:_____
Any other problems we should be aware of:_____

All above information is current and correct:
Parent's Signature_____Date_____