Health Assessment

This Registration Form shall be completed by the legal authorized parent or guardian of minor/child participant. This information may be shared with staff and volunteers for the purpose of the administration of the program.

Child's Name: Last_____ First_____ Date of most recent physical exam_____

Where do you usually take your child for medical care?_____

Name of provider_____ Phone_____

Address of provider_____

Assessment of Child's Health

To the best of your knowledge, does you child have a history of or any problems with the following: Please check "yes" or "no".

Birth Defects	Yes___	No___	Comment_____
Prematurity	Yes___	No___	Comment_____
Hospitalization (when and where)	Yes___	No___	Comment_____
Concussion (head injury)	Yes___	No___	Comment_____
Surgery	Yes___	No___	Comment_____
Lead Poisoning	Yes___	No___	Comment_____
Eye or Vision Problems	Yes___	No___	Comment_____
Ear Problems or Deafness	Yes___	No___	Comment_____
Speech Problems	Yes___	No___	Comment_____
Cerebral Palsy	Yes___	No___	Comment_____
Meningitis	Yes___	No___	Comment_____
Heart Problems	Yes___	No___	Comment_____
Serious Allergic Reactions	Yes___	No___	Comment_____
Behavior or Emotional Problems	Yes___	No___	Comment_____
Allergies – Food, Insect, Drug, etc.	Yes___	No___	Comment (symptoms)_____
Asthma	Yes___	No___	Comment_____
Sickle Cell Disease	Yes___	No___	Comment_____
Diabetes	Yes___	No___	Comment_____
Seizures	Yes___	No___	Comment_____
Bleeding Problems	Yes___	No___	Comment_____
Limits on Activities	Yes___	No___	Comment_____
Problems with Bladder	Yes___	No___	Comment_____
Problem with Bowels	Yes___	No___	Comment_____
Are all immunizations current?	**Yes___**	**No___**	**Comment**_____
Should there be a restriction of physical activity?	Yes___	No___	Comment_____
Are any medications being taken?	Yes___	No___	Comment_____
Special medical procedures that may be needed?	Yes___	No___	Comment_____

Additional information or comments that may be helpful for staff_____

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Signature of parent/guardian_____ Relationship to participant_____

Print name of signatory_____ Date_____ REV. 1/23