Health Form and History
******Please enclose a copy of medical card/insurance information.******

Participant's Name_____ Sex_____
Parish_____
Town/City_____ State_____
Birth Date_____ Age_____
Parent or Guardian_____
Relationship to Participant_____
Street Address_____
City_____State_____Zip_____
Home Phone_____
Work Phone_____
Cell Phone_____
Family Doctor_____Phone_____

Immunizations: Record year of last immunization for the following:
Tetanus/Diphtheria_____ Measles_____
Mumps_____ Chicken Pox_____
Rubella_____ Polio_____

Special Information: Please check all that apply. Information will be held in confidence.

Sleep Walking____	Asthma____	Kidney Problems____
Fainting_____	Frequent Nosebleeds____	Frequent Colds____
Dizziness_____	Seizures_____	Severe Headaches_____
Blackouts_____	Diabetes	Homesickness_____
Frequent Earaches_____	Heart Problems_____	Depression_____

Other_____ Please explain._____
_____
_____
_____

Allergic Reactions: Please list all known allergies: plant, insect, food, medicine, etc.
Indicate **type of reaction** and **treatment:**_____
_____
_____
_____

Does your child require an Epipen? Yes___ No___ If you have answered "yes" please make sure that your child has an Epipen with him/her at all times. He/She will be responsible for administering treatment. We are not allowed to dispense medication.
Please indicate any other **medical problems/conditions**:_____
_____
_____

Any physical limitations? Yes___ No_____ If yes, please explain.
_____
_____
_____

Any emotional/psychological limitations or reactions to be aware of? Yes_____No_____
If yes, please explain._____
_____
_____