Queen of All Saints Summer School Extended Care Program
HEALTH INFORMATION FORM

Child's Name: _____ Age: _____

Parent's Name: _____ Phone: _____

PHYSICAL CONDITIONS: Please note conditions that affect your child, and symptoms that may help us to identify possible problems.

CONDITION YES OR NO SYMPTOMS MEDICATION

ALLERGIES _____

Food _____

Drug _____

Insect _____

ASTHMA _____

DIABETES _____

SEIZURES _____

OTHER? SPECIFY _____

_____

Please list below any other conditions, learning disabilities or health problems of which we should be aware in order to best care for your child:

_____

_____

_____

Does your child have an IEP or 504 plan? Please explain.

_____

_____

_____

LOCAL PERSONS TO BE CALLED IN CASE OF AN EMERGENCY

PLEASE PRINT CLEARLY

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PERSONS (OTHER THAN PARENTS) WHO ARE ALLOWED TO PICK UP THIS CHILD

Name: _____ Relationship: _____ Phone_____

Name: _____ Relationship: _____ Phone_____

Name: _____ Relationship: _____ Phone:_____

PERSONS WHO BY COURT ORDER MAY NOT PICK UP THIS CHILD

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____