PLEASE RETURN THIS COMPLETED FORM ON THE FIRST DAY OF CLASS:

Dates will attend class: from ___________________________ to ___________________________
Month/Day/Year Month/Day/Year

Student Name:

____
First Middle Last

☐ Male ☐ Female Birth Date __________________________ Age on arrival at class: ____________
Month/Day/Year

Parent(s)/Guardian(s): Please complete the forms as thoroughly as possible. Attach additional information if necessary.

Student Home Address:

____
Street Address City State Zip

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name:____ Relationship to Student: ________________________________ Phone: ( )____________________

Email: ____

Home Address:

____
(If different from above) Street Address City State Zip

Second parent/guardian or other emergency contact:

Name:____ Relationship to Student: ________________________________ Phone: ( )____________________

Email: ____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name:____ Relationship to Student: ________________________________ Phone: ( )____________________

ALLERGIES: ☐ No known allergies ☐ This student is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
Please describe below what the student is allergic to and the reaction seen.

DIET & NUTRITION: ☐ This student eats a regular diet. ☐ This student eats a regular vegetarian diet. ☐ This student is lactose intolerant. ☐ This student is gluten intolerant. ☐ Other, *please explain below*:

RESTRICTIONS: ☐ I have reviewed the program and activities of the class and feel the student can participate without restrictions.

☐ I have reviewed the program and activities of the class and feel the student can participate with the following restrictions or adaptations. *(Please describe below.)*

MEDICAL INSURANCE INFORMATION:

This student is covered by family medical/hospital insurance: ☐ Yes ☐ No
Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company: ____ Policy No.:____

Subscriber: ____ Insurance Company Phone Number: ( )____________________

PARKWAY PLAYHOUSE JUNIOR
Student HEALTH FORM

Student Name: ______________________________
First Middle Last

Birth Date: ______________________
Month/Day/Year

GENERAL HEALTH HISTORY: Check "Yes" or "No" for each statement. Explain the "Yes" answers below.

1. Ever been hospitalized? ☐ Yes ☐ No
2. Ever had surgery? ☐ Yes ☐ No
3. Have recurrent/chronic illnesses? ☐ Yes ☐ No
4. Had a recent infectious disease? ☐ Yes ☐ No
5. Had a recent injury? ☐ Yes ☐ No
6. Ever had back/joint problems? ☐ Yes ☐ No
7. Had seizures? ☐ Yes ☐ No
8. Had headaches? ☐ Yes ☐ No
9. Wear Glasses, Contacts, or Protective Eyewear? ☐ Yes ☐ No
10. Had fainting episodes or dizziness? ☐ Yes ☐ No
11. Passed out/had chest pain during exercise? ☐ Yes ☐ No
12. Had mononucleosis ("mono") during the past 12 months? ☐ Yes ☐ No
13. If female, have problems with periods/menstruation? ☐ Yes ☐ No
14. Had asthma/wheezing/shortness of breath? ☐ Yes ☐ No
15. Have diabetes? ☐ Yes ☐ No
16. Have skin problems? ☐ Yes ☐ No
17. Traveled outside the country in the past 9 months? ☐ Yes ☐ No

Please explain the "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name the countries visited and dates of travel.

MENTAL, EMOTIONAL AND SOCIAL HEALTH: Check "Yes" or "No" for each statement.
Has the student:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐ Yes ☐ No
2. Every been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, been seen by a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the student's life? ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption foster care, new sibling, survived a disaster, other)

Please explain "Yes" answers in the space below, noting the number of the questions. The class may contact you for additional information.

HEALTH CARE PROVIDERS:

Name of student's primary doctor(s): ______________________ Phone Number: ( )__________

Name of dentist(s): ______________________ Phone Number: ( )__________

Name of orthodontist(s): ______________________ Phone Number: ( )__________

WHAT HAVE WE FORGOTTEN TO ASK? Please provide, in the space below, any additional information about the student's health that you think important or that may affect the student's ability to fully participate in the class. Attach additional information if needed.