Information Update

Name____________________ Date__________

Please Fill out this section completely and sign below.

Health History	Yes	No
Behavioral, learning or mental disabilities......................	☐	☐
Epilepsy or seizure disorder	☐	☐
Allergic reaction to any medication	☐	☐
If so what? ______________________________		
Heart Problems (murmurs, surgery, etc.)	☐	☐
Recent surgeries or serious illness	☐	☐
Is your child currently taking any medications?	☐	☐
If yes, what? ______________________________		
Positive HIV test	☐	☐
Pregnant..	☐	☐

Other ______________________________

Child's address and telephone:

____

____

Parent's name, address & phone if different from child)

____________________ Phone ____________

____________________ Cell# ____________

Parent's employer: ______________________

Parent's work telephone: ________________

Dental Insurance Info: ___________________

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Policy Holder's Date of Birth ______________

Parent's Sig ____________________________

Email ________________________________

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