MOUNT PLEASANT AFTER-SCHOOL PROGRAM
HEALTH HISTORY FORM

(PLEASE COMPLETE ONE FORM PER PERSON)

Student:_____ M__ F__ Birthdate _____/_____/_____

Address: _____Apt.#_____ City_____ Zip_____

Parent/Guardian Name _____Home Phone #_____ Cell #_____

E-mail address _____

Employed by _____Occupation _____

Business Phone # _____Employee#_____

EMERGENCY INFORMATION

Alternative person to be called in case of an emergency:

Name Phone Relationship

_____

_____

_____

INFORMATION REOUIRED BY STATE LAW

Health Insurance Co.:_____

Policy Number: _____

Family Physician:_____

Phone: _____

Family Dentist: _____

Phone: _____

ALLERGIES (PLEASE CHECK)

Hay Fever ___Yes ____ No

Oak/Ivy Poisoning ___ Yes ____ No

Foods ___ Yes ____ No

Any other Allergies? ___ Yes ____ No

Bee Stings ___ Yes___ No ___Unknown

Other Drugs ___ Yes ___ No

Penicillin ____Yes ____No

If yes to any of the above please describe:

_____

_____

_____

PARENTS AUTHORIZATION (If under the age of 18)

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Mount Pleasant After-School to hospitalize, and/or secure proper treatment.

Parent Signature: _____ Date: _____