

Deerwander 2009 Bible Conference

Health Form

First Name _____ Mi ____ Last Name _____ D.O.B. _____

Street, Box # _____ Town _____

State _____ Zip _____

Home Phone # _____

Record of immunizations: Please list the date of the last booster received for each of the following:

DPT _____ Oral Polio _____ Rubella _____ DT _____ MMR _____ Mumps _____

Tetanus _____ Measles _____ TB test _____ Hep B _____ Lyme's _____

Chicken pox _____ Hepatitis B _____

Date of child's last physical exam _____

Examination: Height _____ Weight _____ B/P _____ Pulse _____

Any abnormalities noted _____

Please list any illness or past or present medical conditions that our medical staff should know about.

Is your child presently under a doctor's care for anything? If yes, please describe. _____

Are there any restrictions in your child's physical activity? If yes, please specify _____

Does your child have any dietary restrictions? If yes, please specify. _____

Does your child have any allergies to food _____ environment _____ medications _____?

If yes, please specify _____

Physician's signature or office stamp _____

Physician's name _____ Phone # _____

Physician's address _____
