Health Care Form

Luther Crest Environmental Program

Student's Name _____

Mailing Address _____

Date of Birth _____ Sex _____ Age _____

Parent/Guardian's Name _____

Home Address _____

Home Phone _____ Business Phone _____

Student's Doctor _____

Type of Insurance:

Company Name _____ Policy Number _____

Company Address _____

General Health History: (Check – giving approximate dates)

Frequent Ear Infections	_____	Psychiatric Care	_____
Heart Defect/Disease	_____	Vision Impaired	_____
Convulsions	_____	Depression	_____
Diabetes	_____	Measles/Mumps	_____
Blood/Clotting Problems	_____	Learning Disability	_____
Hypertension	_____	ADHD, ADD	_____
Hay Fever, Allergies	_____	Hearing Impaired	_____
Insect Stings	_____	Penicillin	_____
Anxiety, Anger	_____	Asthma	_____

Immunizations:

Is your child's immunization history up-to-date? YES or NO

Special Information:

Is this student taking any medications at present? YES or NO

If yes, please explain _____

Please list any special needs the student may require while at the Center, e.g., handicapped accessible bathrooms, housing, dietary needs, etc.: _____

_____

Does the student use crutches, braces, wheelchair, etc.? _____

_____

We will call you in case of an emergency requiring professional medical treatment or if we have questions about your child. The information contained in this Health Form is only shared with staff if necessary and Hospital Clinic Staff. This form will be securely stored in Luther Crest's records for 20 years as required by law and then destroyed. By signing this document, I give permission for my child to participate in all activities and for Luther Crest to seek emergency treatment and to select medical personnel and to order X-rays or routine tests or treatment if the situation arises.

Parent/Guardian Signature _____ **Date** _____