# HEALTH HISTORY

This form is to be completed by parent/guardian. This information will be kept confidential and used only for the welfare of the participant.

NAME: ________________________________ DATE OF BIRTH: ________________

SEX: __________ SCHOOL: ______________ GRADE: __________________

PARENT/GUARDIAN: _____________________________________________________

ADDRESS: ______________________________________________________________

PHONE (Daytime): ________________________ OTHER: _______________________

MED. ALLERGIES: (Prescription or non-prescription) ______________________________
_______________________________________________________________________

BEE/WASPS STING ALLERGY? yes / no Prescribed treatment: _________
_______________________________________________________________________

PHYSICIAN: _____________________________ PHONE #: _____________________

PRESENT MEDICAL CONDITION: _____________________________________________
_______________________________________________________________________

PRESENT MEDICATIONS (and instructions): ___________________________________
_______________________________________________________________________

DATE OF LAST TETANUS BOOSTER: __________

CHECK IF PARTICIPANT IS SUBJECT TO:

_____ Headaches _____ Seizures/Convulsions _____Home Sickness
_____ Sinusitis _____ Ear Infection _____ Fainting
_____ Bronchitis _____ Asthma _____ Constipation
_____ Diarrhea _____ Sleep Walking _____ Cramps

Check medications that participant may receive if deemed necessary and administered by an Adult Sponsor of Skywatchers.

_____ Antacids _____ Acetaminophen (Tylenol) _____ Ibuprofen
_____ Cold Medications _____ Cough Medications _____ Laxatives
_____ Diarrhea Medications

Signature: ________________________________ Date: __________________