SUMMER 2015
Health Examination Form

Child’s Name: __________________________________________________________

In case of emergency, notify _____________________________________________
BEST Phone: ___________________ Home Phone: __________________________

Health and Accident Insurance Company: _________________________________
Policy Holder: ___________________ Policy No.: __________________________

Enclose specific instructions on procedures staff of Learn2Serve should use in case of an emergency.

**Health History**

Has your child experienced any health problems? Yes ________ No ________
If yes, please specify. ____________________________________________________

Allergies: Yes ________ No ________
If yes, please specify. ____________________________________________________

Has your child been exposed recently to any communicable disease? Yes ________ No _______
Explain: __________________________________________________________________

You must notify the camp if this occurs.

Does your child take medication for any reason? Yes ________ No ________
If so, please explain reason, dosage, and time of administration. Does he/she administer these medications independently? If not, what kind of help is needed? Explain.
__________________________________________________________________________

Has your child been evaluated or received treatment or counseling by a psychologist or physician for an emotional, attention or behavior problem? Include copies of any evaluations or reports that are relevant to your child’s learning or participation in this program.

Do you have any concerns about your child’s health? (Please add a separate statement, if necessary.)

I certify that this health history is accurate and complete. My child, ____________________, has my permission to participate in all the activities of the camp with the exception of those indicated by the physician on this form. In addition, if I cannot be reached in case of an emergency, I give permission for my child to be taken to West Georgia Health Hospital.

__________________________________________________________________________

Parent or Legal Guardian ___________________ Date ___________________