

Canfield Kids Health Status Form for School Age Children

Child's Name: _____

Date of Birth: _____ Grade in September: _____

Is your child under any medical/physical restrictions? Yes _____ No _____
If yes, check all that apply:

Asthma _____ Diabetes _____ Seizures/Convulsions _____

Other: _____

Is your child taking any medication? Yes _____ No _____ If yes, please list: _____

Has your child been under a doctor's care or hospitalized within the last three years?

Yes _____ No _____ If yes, please explain: _____

Is your child allergic to any medications/foods/insect stings? Yes _____ No _____

If yes, please list: _____

Family Health Care Provider's Name: _____

Telephone Number: (_____) _____

Address: _____

As a parent/guardian of the above participating child, I certify that he/she is in good physical health, has no special needs, and may participate in all of the activities of the Center's program, except as noted above.

Parent/Guardian Signature : _____ Date: _____