



Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone(H) (\_\_\_\_\_) \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_

Mother's Name \_\_\_\_\_ Phone (H)(\_\_\_\_\_) \_\_\_\_\_ (W)(\_\_\_\_\_) \_\_\_\_\_

Father's Name \_\_\_\_\_ Phone (H)(\_\_\_\_\_) \_\_\_\_\_ (W)(\_\_\_\_\_) \_\_\_\_\_

Emergency Phone (H)(\_\_\_\_\_) \_\_\_\_\_ (W)(\_\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

Date of last Tetanus Booster \_\_\_\_/\_\_\_\_/\_\_\_\_

May your child swim? YES NO

Do you know of any health information that requires your child to have any limitations in his or her activity? YES NO  
(If yes, please explain in the space below.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child presently on any medication? YES NO (If yes, please list medication(s), dosage, and time of administration.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Describe any significant medical condition about which we should be aware!

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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Does your son/daughter have? (If yes, please explain)

YES  NO Allergies \_\_\_\_\_

YES  NO Heart Condition \_\_\_\_\_

YES  NO Diabetes \_\_\_\_\_

YES  NO Asthma \_\_\_\_\_

YES  NO Seizures \_\_\_\_\_

YES  NO Other \_\_\_\_\_

Is your son/daughter subject to? (If yes, please explain)

YES  NO Fainting \_\_\_\_\_

YES  NO Sleep Walking \_\_\_\_\_

YES  NO Upset Stomach \_\_\_\_\_

YES  NO Other \_\_\_\_\_

Does your son/daughter react to? (If yes, please explain)

YES  NO Bee Sting \_\_\_\_\_

YES  NO Penicillin \_\_\_\_\_

YES  NO Other Drugs \_\_\_\_\_

YES  NO Poison Ivy, Oak, Sumac \_\_\_\_\_

YES  NO Food \_\_\_\_\_

YES  NO Other \_\_\_\_\_

Please answer the following.

YES  NO Did your son/daughter have a serious illness in the last year? Illness? \_\_\_\_\_

YES  NO Did your son/daughter have surgery within the last year? Type of Surgery? \_\_\_\_\_

YES  NO Does your son/daughter have any sight or hearing impairment?

YES  NO Does your son/daughter wear contact lenses?

In the event of an accident or illness, I give my permission for an adult chaperone to take my child to a doctor or emergency room at my expense. I understand that I will be notified as soon as possible. I/We agree not to hold Liberty High School administration, faculty or any staff member liable.

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_