SHOW STOPPERS- HEALTH RECORDS

(This side to be filled in by Parent before presentation to Physician)

NAME OF PROGRAM: _____

_____ _____

Child's Last Name First Name

____/____/____ Male/ Female

Date of Birth Sex

Home Address: _____

Tel. No. _____

Parent or Guardian: _____

Tel. No. _____

Place of Employment: _____

Father Guardian: _____

Tel. No. _____

Mother Guardian: _____

Tel. No. _____

In Case of Emergency, please notify: _____

Tel. No. _____

If Parent/Guardian are not available in an emergency, please notify:

1. _____

Tel. No. _____

2. _____

Tel. No. _____

Important: Has your child been exposed to any communicable disease during the three weeks prior to program attendance.

☐ Yes ☐ No

If yes, state type of exposure: _____

_____

_____

HEALTH HISTORY

(Check and give approximate dates)

Allergies Diseases _____
Ear Infections _____
Hay Fever _____ _
Check Pox _____
Rheumatic Fever _____
Ivy Poisoning, etc. _____
Measles _____
Convulsion _____
Insect Stings _____
German Measles _____
Diabetes _____
Penicillin _____
Mumps _____
Behavior _____
Other Drugs _____
Other Contagious Illnesses _____
Asthmas _____ _____

Other Past Illnesses: _____
Operations or Serious Injuries (Dates): _____
Hospitalization (Dates): _____
Chronic or Recurring Illness: _____
Any specific activities to be encouraged? _____
Conditions that require activity to be restricted? _____
Permission for all program activities unless otherwise noted by doctor: _____
Appliance worn (glasses, contacts, etc.): _____
Medication taken: _____
Suggestion from Parent/Guardian: _____
_____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Queens Theatre staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

_____	_____	_____	_____
Relationship	Signature	Date	Tel. No.