Center for Excellence in Learning through Service

Trades Building, Second Floor
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www.berea.edu/celts

Child Health History Form

The information on this form is not part of the program acceptance process, but is gathered to assist us in identifying appropriate care should the need arise. Any changes to this information provided on this form must be provided to program personnel immediately. Provide complete information so that staff will be aware of your child's needs.

Participant's Name _____ Birth Date _____

Home Address _____

School _____ Grade _____ Gender: __Male __Female

Parent/legal guardian _____

Home Address _____ Phone _____

(If different from above)

Business Address _____ Phone _____

Second parent or legal guardian or emergency contact _____

Address _____ Phone _____

Additional emergency contact _____ Relationship _____

Address _____ Phone _____

In all emergencies when prior authorization cannot be obtained from me or the other emergency contacts specified above, I authorize Berea College's CELTS program staff to secure emergency medical treatment on my child's behalf, including surgery and the administration of an anesthetic. I accept all financial responsibility for such treatment and expenses. I agree to release, indemnify and hold harmless Berea College, its trustees, officers, employees, students and agents, including staff of CELTS, in connection with any treatment rendered pursuant to the permission given in this document.

This form may be photocopied for trips off Berea College premises.

Information on this form may be shared with Berea College staff and students involved with CELTS programs.

_____ _____

Parent or Legal Guardian Signature **Date**

Insurance Information

Is the participant covered by family medical insurance? __ Yes __ No
If so, indicate carrier or plan name _____ Group # _____
Name of insured _____ Relationship to participant _____

Allergies

List all known allergies. Describe reaction and management of the reaction.

Medication allergies (list)

_____
_____
_____

Food allergies (list)

_____
_____
_____

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

_____
_____
_____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Any medications that must be taken during program time should remain in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

__ This person **takes NO medications** on a routine basis OR
__ This person **takes medications** as follows:

Med. #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Med. #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Attach additional pages for more medications.

RESTRICTIONS (The following restrictions apply to this individual.)

Does not eat: __ Red meat __ Pork __ Dairy Products __ Poultry __ Seafood __ Eggs __ Other _____

Explain any restrictions to activity (e.g. activities in which the child cannot participate). _____
_____
_____

Use this space to provide additional information about the participant's behavior and physical, emotional, or mental health about which our programs' staff should be aware. _____
_____
_____

Name of family physician _____
Address _____
Phone _____