General Information/Health History

Full name: _____

Date of birth: _____

Emergency Contact: _____

Phone Number: _____

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? Exp. date (if yes) _____ ☐ YES ☐ NO

DO YOU USE AN ASTHMA RESCUE INHALER? Exp. date (if yes) _____ ☐ YES ☐ NO

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain
		Medication	
		Food	

Yes	No	Allergies or Reactions	Explain
		Plants	
		Insect bites/stings	

List all medications currently used, including any over-the-counter medications. ☐ Check here if no medications are routinely taken.

*** Place all medication in a sealed bag, clearly marked with child's full name.**

Medication	Dose	Frequency	Reason

☐ Administration of the above medications is approved for youth by:

_____ / _____

Parent/guardian signature

Print Name and Date