

Deerwander 2007 Bible Conference Health Form

First Name _____ Mi ____ Last Name _____ D.O.B. _____
Street, Box # _____ Town _____
State _____ Zip _____
Home Phone # _____

Record of immunizations: Please list the date of the last booster received for each of the following:

DPT _____ Oral Polio _____ Rubella _____ DT _____ MMR _____ Mumps _____
Tetanus _____ Measles _____ TB test _____ Hep B _____ Lyme's _____
Chicken pox _____ Hepatitis B _____

Date of child's last physical exam _____
Examination: Height _____ Weight _____ B/P _____ Pulse _____
Any abnormalities noted _____

Please list any illness or past or present medical conditions that our medical staff should know about.

Is your child presently under a doctor's care for anything? If yes, please describe.

Are there any restrictions in your child's physical activity? If yes, please specify _____

Does your child have any dietary restrictions? If yes, please specify.

Does your child have any allergies to food _____ environment _____ medications _____?
If yes, please specify

Physician's signature or office stamp _____
Physician's name _____ Phone # _____
Physician's address _____