YORKVILLE YOUTH ATHLETIC ASSOCIATION, AFTER SCHOOL AT P.S. 59

CHILD'S HISTORY – HEALTH INVENTORY

To be completed by parent or guardian:

Child's Name ______________________________ Birth Date _______________ Sex _______________

Address: ____ Apt. _____________ Zip _______________

Home Phone ___________________ E-Mails ____

Father Cell _____________________________ Mother Cell ____________________________________

Father Work ____________________________ Mother Work ____________________________________

Parents Names: _________________________ Sitters Name/ Cell _______________________________

Emergency Contact: Name ___________________________ Phone ______________________________

Name ___________________________ Phone ______________________________

MEDICAL HISTORY – Please describe any accidents, operations or hospitalizations:

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CMMUNICABLE DISEASES – Please check those which your child has contracted:

____ Chicken Pox ____ Measles ____ Mumps Others ____

____ Whooping Cough ____ Rubella (German Measles)

CHRONIC CONDITIONS – Please check those which your child suffers from:

____Allergy (Food) ____ Diabetes ____ Sickle Cell Diseases

____ Allergy (Drug) ____ Epilepsy ____ Others ___________________________________

____ Rashes ____ Heart Disease ___________________________________

____ Asthma ____ Rheumatic Fever ___________________________________

____ Convulsions ____ Breathing Difficulties ___________________________________

If you checked any of the above please give details:

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Is your child taking any medications regularly? ______ If so, which one(s) __________________________

COMMENTS ____

PLEASE INDICATE ANY CONCERNS OR DIFFICULTIES

____ Frequent Colds ____ Vision Difficulties ____ Easily Angered

____ Frequent Sore Throats ____ Hearing Difficulties ____ Worries a lot

____ Frequent Ear Infections ____ Speech Difficulties ____ Tantrums

____ Running Ears/Earaches ____ Frequent Urination ____ Many Fears

____ Nosebleeds ____ Behavioral Concerns ____ Shyness

____ Toothaches ____ Sleeping Problems ____ Excitable

____ Pain in legs/joints ____ Eating Problems ____ Bed Wetting

COMMENTS ____

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Has Child attended after school programs previously? ____ Yes ____ No

Please feel free to use the reverse side of this page to tell us anything else we should know about your child