

# LISD HEALTH HISTORY FORM

Name \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Telephone \_\_\_\_\_

Home address \_\_\_\_\_

Street & Number

City

State

Work address \_\_\_\_\_ Telephone \_\_\_\_\_

Street & Number

City

State

Name of family Doctor \_\_\_\_\_

Telephone: \_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_

Telephone: \_\_\_\_\_

Family medical/hospital insurance:

Carrier: \_\_\_\_\_

Policy number \_\_\_\_\_

## Important – The following must be completed for attendance.

Lovejoy ISD faculty and staff have my permission to: (Check all that you grant permission for.)

Provide first aid treatment, if necessary for minor situations such as upset stomach, headache, cuts, stings, and bruises.





Dispense medications that have been provided from home, according to the dosages listed below and on the medication's dosage label. *(Please indicate each medication below and the appropriate dosage.)*

\_\_\_\_\_  
Parent or Guardian Signature

# Lovejoy ISD Camp Health History Form

**Please explain in detail any treatments that may apply to following---**

Student Name: \_\_\_\_\_

<p><b>Taking the following medications...</b></p> <p style="text-align: center;"></p>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p><b>Allergic to the following medications, plants, animals, foods, insects, etc...</b></p> <p style="text-align: center;"></p>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p><b>In need of special attention with regard to Asthma, Diabetes, Blood Disorders, Seizure Disorders, Heart Disease or any other major medical problems ...</b></p> <p style="text-align: center;"></p>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p><b>Any type of Physical Restrictions</b></p> <p style="text-align: center;"></p>	<hr/> <hr/> <hr/> <hr/>

This health history is correct as far as I know, and the person listed above has permission to engage in all prescribed camp activities except as noted. I hereby give permission to Lovejoy ISD staff: 1) to provide ongoing health care; 2) to select medical personnel and to order X-rays or routine tests or treatment for the person listed above.

**Emergency Authorization:** In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Lovejoy ISD staff to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and /or surgery for the person named above. This form may be photocopied for use out of camp.

Signature of parent or guardian: \_\_\_\_\_ Date \_\_\_\_\_