General Health Form

First Name:____________________ Last Name:_________________________
DOB: ___/___/______ Male:____ Female:____

Emergency Contact: ____
Phone:______________________

<u>Allergies:</u>

Are you allergic to any Medications? No:______ Yes: (please list)____________________

Are you allergic to any Food? No:______ Yes: (please list) _________________________

Do you have any Other allergies? No:________ Yes: (please list)____________________

<u>Other:</u>

Have you been exposed to any communicable diseases recently?

No:_____ Yes: (please explain)____

Is there any other Medical or Additional information our staff should be aware of
(ex: Dietary, Disability, Major operations, Special precautions, Seizures, Emotional concerns)

No:_____ Yes: (please explain)____