ST. BERNADETTE EXTENDED DAY PROGRAM - MEDICAL HISTORY

Student's Name: _____ Birth Date: _____

Student's Physician: _____

Physician's Address: _____

Date of Last Physical Exam: _____

Preferred Hospital: _____

Hospital Address: _____

Clinic/Hospital Number: _____ Medical Insurance: _____

Insurance Number: _____ Group Number: _____

Has your child had any of the following illnesses?

YES	NO		YES	NO	
O	O	Mumps	O	O	Polio
O	O	Measles	O	O	Scarlet Fever
O	O	Chicken Pox	O	O	Whooping Cough

Other: _____

Does Your child have food Allergies? No ( ) Yes ( ) Please list below

_____

_____

Does your child have Asthma? No ( ) Yes ( ) Please detail your instructions in the event of an attack:

_____

_____

_____

Does your child have any physical, mental and/or emotional problems that may restrict his/her activity during the extended day? No ( ) Yes ( ) Please specify: _____

_____