Health Information Form

TO BE COMPLETED BY PARENT OR GUARDIAN EACH SESSION

Student Name Last First Sex ☐ M ☐ F DOB

Complete all boxes that apply to the student listed above. Parent or guardian is responsible to provide to studio with any medications, special food or equipment the student may require while they are in our facility.

☐ ALLERGIES

Allergy Type

☐ Food List food(s)_____

☐ Medications List medication(s)_____

☐ Bee Sting _____

☐ Other Intolerance(s) _____

☐ ASTHMA

Triggers ☐ Exercise ☐ Environmental ☐ Other (list) _____

Symptoms

☐ Chest tightness, discomfort or pain ☐ Difficulty breathing ☐ coughing

☐ Other _____

Currently Prescribed Medications and Treatments for the above and or others

☐ Inhalers ☐ Oral antihistamines ☐ Oral Steroids

☐ Other _____

☐ _____ will be left at Island Dance and I give my permission for the above medication to be given to my child if I am not present. Any additional medication being left, will need a new form to be filed.

Signature _____ Date _____

Physical Limitations continued on page 2

Physical & Mental Limitations

In order for our teachers to best instruct your student _____ , we need to be aware of any physical and or mental limitations your student has.

( ) Any orthopedic impairment resulting in skeletal, muscular or neuromuscular impairment resulting from disease, congenital, or other causes such as cerebral palsy, amputations, burns that cause contractures, spinal cord injuries.

( ) A traumatic brain injury resulting in an open or closed head injury acquired from an external force including near drowning, motor vehicle accidents, and falls but not including congenital or degenerative conditions, or conditions resulting from birth trauma.

Diagnose and describe the condition checked above:

_____

_____

Date of Onset:_____

Check if the condition is stable ( ) Progressive ( ) Chronic ( ) Acute ( )

Does your child suffer from any mental health disorders? ( ) Yes ( ) No

If yes, please describe. _____

_____

What can be done by our staff to help your child when they are experiencing any of the above? _____

_____

If your child has been prescribed any medication, please indicate and complete page one. ( ) yes ( ) No..

Signature _____ Date _____