

# GUMY/ TY Medical Form

Child's Name	
Address:	
City, State Zip:	
Date of Birth:	Current School Grade:
Mom's Name:	
Dad's Name:	
Mom's Phone Numbers:	
(H) _____	
(W) _____	
(C) _____	
Dad's Phone Numbers:	
(H) _____	
(W) _____	
(C) _____	
Family Doctors:	
Name: _____	
Phone: _____	
Insurance Company Name:	
_____	
Phone : _____	
Policy #: _____	
Group #: _____	

7. Does your child have any physical handicap or illness preventing his/her participation in normal rigorous activity?  
**Yes No**

8. Please circle one. My child **can** / **cannot** swim.

9. Administer to my child upon his or her request : **Yes No**  
 \_\_\_\_\_ Ibuprofen, dosage \_\_\_\_\_  
 \_\_\_\_\_ acetaminophen, dosage \_\_\_\_\_

Please explain any "yes" questions 1 through 9:

---



---



---



---



---

1. Is your child presently being treated for an injury or sickness, taking any medication or carrying any emergency medications? **Yes No**

Medications	Dose	Taken for?

2. Is your child allergic to any type of medications? **Yes No**

3. Does your child require a special diet? **Yes No**

4. Does your child have (or ever had) any of the following?

(circle, then explain in space after #9)

- |                         |                                 |
|-------------------------|---------------------------------|
| _____ Physical handicap | _____ Head injury               |
| _____ Seizure disorder  | _____ Food allergy              |
| _____ Asthma            | _____ Environmental allergy     |
| _____ Kidney Disease    | _____ Diabetes                  |
| _____ Heart Condition   | _____ Behavior/nervous disorder |
| _____ Stomach problem   | _____ Other                     |

5. Does your child have any allergies other than medicines: **Yes No**

6. Does your child sleep walk: **Yes No**