CRASH ZONE
HEALTH INFORMATION FORM

Parent/Guardian: Please complete and return this form. We require that the parent/guardian of any student notify Crash Zone of any medication being taken by the child on a regular basis. Thank you

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STUDENT INFORMATION

NAME____

BOY ☐ GIRL ☐ DATE OF BIRTH ___________________________

INSURANCE
Name of insurance program _________________________ Policy # _______________________________

DOCTOR
NAME ____ PHONE # ________________________________

DENTIST
NAME ____ PHONE # ________________________________

HEALTH INFORMATION
Has your child had any health condition related to the following? If so, please check the box & describe.

☐ Asthma ☐ Diabetes ☐ ADD ☐ Ear Infections ☐ Blood Disorder ☐ Other
☐ Hypoglycemia ☐ Kidney ☐ ADHD ☐ Nosebleeds ☐ Physical Disability
☐ Anxiety ☐ Special Diet ☐ Migraines ☐ Depression ☐ Cancer/Tumor/ Leukemia
☐ Heart Condition ☐ Headaches ☐ Hepatitis ☐ Food Allergies ☐ Epilepsy/ Seizure Disorder
☐ Behavioral Problems ☐ Eczema/ Skin Sensitivity

If you marked any of the above, please describe:____
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____
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Does your child require Emergency Medication at Crash Zone? ☐ Yes ☐ No

☐ Epi Pen ☐ Benadryl ☐ Albuterol Inhaler ☐ Glucagon ☐ Other

Please specify:____

OTHER IMPORTANT HEALTH INFORMATION

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_____________________________________ _________________________
Signature of Parent/Legal Guardian Date