“Get Moving” Health Information

Student Name: _____ Date of Birth:_____ Current Grade: _____

Address: _____

Parent/Guardian: Name _____ Cell _____

Parent/Guardian: Name _____ Cell _____

Other Person(s) permitted to pick up: Name _____ Cell _____
Name _____ Cell_____
Student returns to Latchkey after “Get Moving” program _____ Yes _____ No

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Health History: Circle health conditions experienced by your child. Please explain circled conditions below.

Allergies (food, animals, meds, others) Asthma Constipation Diabetes Fainting
Fractures Hearing loss Seizures Surgery Vision issues Other:

Explain all circled conditions: (please attach any current health plans in place)

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Behavioral, Emotional, Social Health History: Circle and explain health conditions for your child.

ADD/ADHD Autism spectrum Behavior concerns/plan Eating concerns Other:

Explain all circled conditions: (please attach any current behavior plans in place)

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Medications taken at home: _____

Medications coming to program: _____

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Restrictions: List any activity restrictions or adaptations that would benefit participant

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Health Care Providers
Primary Care: _____ Phone: _____

Dentist: _____ Phone: _____

Signature of Person Completing Health Form: _____