PERMISSION SLIP & HEALTH FORM

# Date Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has my/ our permission to attend the

 (Please Print)

# Annual Winter Retreat from March 6, 2020 to March 8, 2020 we authorize

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as temporary guardian to obtain any medical and/or

 (Please Print)

surgical care deemed necessary in the emergency room for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Please Print)

who is my son/daughter. Age\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Insurance:**

# Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Please Print)

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Area Code (Home)

# City & State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Area Code (Work)

x \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ x \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Both Parents or Guardian Signature)

**1.) What disease has he/she had?** (Circle all those applicable): measles, mumps, whooping cough, tonsillitis,

Scarlet fever, undulant fever, rheumatic fever, impetigo, bronchitis, infantile paralysis, trench mouth, head lice,

Pneumonia, meningitis, chicken pox, others (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.) Has he/she been ill the last three weeks? Yes \_\_\_\_\_ No \_\_\_\_\_ if yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.) Does he/she have any physical disabilities? Yes\_\_\_\_\_ No\_\_\_\_ If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does he/she have any allergies? Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.) Does he/she take medicine? Yes\_\_\_\_\_ No \_\_\_\_\_ If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6.) Has he/she had a tetanus shot? Yes\_\_\_\_ No \_\_\_\_\_ If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is your child subject to (check all that apply):

\_\_\_\_\_Headaches \_\_\_\_\_Talking in sleep \_\_\_\_\_Spasms \_\_\_\_\_Draining ears

\_\_\_\_\_Nose Bleeds \_\_\_\_\_Sleep walking \_\_\_\_\_Hay fever \_\_\_\_\_Nightmares

\_\_\_\_\_Motion Sickness \_\_\_\_\_Bed wetting \_\_\_\_\_Asthma \_\_\_\_\_Indigestion

\_\_\_\_\_Fainting \_\_\_\_\_Sinus Infection \_\_\_\_\_Hysterias \_\_\_\_\_Constipation

8.) Is there anything else you think we should know? If so, please indicate on back: