C. A. F. A.
Children's Academy of Fine Arts, Inc.

REGISTRATION HEALTH FORM

Date_____

Name:_____ Age_____ Birthdate:_____
Last First
Address:_____

_____

Parent/guardian: Do you have medical insurance?_____If so, please list type of plan, company, and policy number(s):_____

_____

Does this student have any DRUG ALLERGIES?_____If yes, please give details-What drug

What type of reaction? How long ago does the reaction occur? _____

_____

_____

Is this student allergic to BEE STINGS?_____If yes, what happens if stung? _____

_____

_____

MEDICAL HISTORY: Please check the following diseases and/or conditions student has had and give approximate dates as appropriate.

Chicken Pox_____ Convulsive Disorder_____ Asthma _____

German Measles_____ Measles _____ Diabetes_____

Strep Infection_____ Poliomyelitis_____

Rheumatic Fever_____ Whooping Cough_____

Allergies/hay fever_____

Does this camper have any other medical conditions which may limit his/her participation in any CAFA activities or which should be of special concern to the staff?_____ If yes, please explain in detail.

_____

_____

_____

Is this student receiving psychiatric care or counseling?_____ If yes, please explain.

_____

_____

_____

IMMUNIZATIONS:
Please list dates
DPT_____ Polio Vaccine_____ Measles_____

Mumps_____ Rubella_____ DPT Booster_____

Other_____ Tuberculin Test: Type_____ Date_____ Results_____

Name & Address of PHYSICIAN

_____

_____Phone_____

Signature of Physician_____
The obtaining of the Physician's signature is strictly at the option of the parent/guardian.

Please return this form at the next CAFA program date.