

**CTK Medical Information Form**

Child's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Does your child have allergic reactions to the following (if yes, please explain)

\_\_\_ Yes \_\_\_ No Food \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Medications \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Insect Bites \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Seasonal Allergies \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Other \_\_\_\_\_

Is child subject to any of the following (if yes, please explain):

\_\_\_ Yes \_\_\_ No Fainting \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Upset Stomach \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Nose Bleeds \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Other \_\_\_\_\_

Please note **ANYTHING** that we should know concerning your child's health:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child on any prescribed medication? (If yes, please explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Our medication policy is described fully in the Parent Handbook*

Signature of Parent or Legal Guardian: \_\_\_\_\_