

Child Registration

Name: _____ Date: _____

Birthdate: _____ Age: _____ Nickname: _____

Father: _____ Mother: _____

Address: _____

Telephone #: _____ Child's Weight: _____

Father's Insurance Company: _____

Group #: _____ Address: _____

Father SSN: _____ Father DOB: _____

Mother's Insurance Company: _____

Group #: _____ Address: _____

Mother SSN: _____ Mother DOB: _____

Who is financially responsible for child?

Health History: Please check all that child has or has had in the past.

___ Anemia

___ Diabetes

___ Hepatitis

___ Allergies (please list)

___ Abnormal Heart Condition

___ Abnormal bleeding from a cut

___ Rheumatic fever

___ Heart murmur

Any other medical conditions: (please list)

Current Medications:

Name of Physician: _____ Phone #: _____

Signature of Parent/Guardian: _____ Date: _____
