Patient ID:

BETHESDA PEDIATRICS SUPPLEMENTAL HEALTH HISTORY

Please complete the following information to the best of your knowledge. Our physicians will review this information prior to completing your child's form.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**
Reason for Completing Form:	☐ School ☐ Daycare ☐ Camp ☐ Sleepaway Camp (lasting 1 month or longer)		
Best Contact Phone Number: ( ) - -		**Person Completing Form:**	

Allergies:	☐ Medications	☐ Environmental
	☐ Food	Does your child require emergency medicine? (i.e. Epi-Pen, Auvi-Q) ☐ Yes ☐ No
	☐ Insects	
Any dietary restrictions?	☐ Gluten Free ☐ Vegan ☐ Vegetarian ☐ Other (please explain)	

List any ongoing medical problems

***In the past year,* has your child had any significant injuries or illnesses?** ☐ Yes ☐ No

Date	Injury or Illness

***In the past year,* has your child been hospitalized?** ☐ Yes ☐ No

Date	Reason	Hospital

***In the past year,* has your child had any surgeries?** ☐ Yes ☐ No

Date	Reason	Surgeon/ Hospital

***In the past year,* has your child seen or been treated by any specialists?** ☐ Yes ☐ No

Date	Reason	Name of Doctor

Are there any physical restrictions that limit your child's activity? ☐ Yes ☐ No

If yes, please explain briefly.

Please list any medications your child is currently taking. This includes <u>prescription medications, over the counter medications, vitamins and/or supplements.</u>

Name the Drug	Strength	Frequency Taken	Will they be taking these medications at camp?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Signature:		**Date:**	