Taipei Youth Program Association
Medical History Form

Child's Name: ______________________ M___ F___ Date of Birth: ___________

Parent or Guardian: ______________________ Phone Number: ________________

If unable to contact parents
Emergency Contact: ___________________ Phone Number: ___________________

Illnesses and Health Problems

Check if your child has had the following:

Allergies______ Diabetes______ Heart Disease______ Seizures______

Information regarding this problem: ______________________________________

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Any previous injuries or surgery? ____

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Any special health-related needs of the child? ______________________________

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Any medications your child takes on a regular basis?

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Parent's Signature: ___________________________ Date:__________________