



Taipei Youth Program Association Medical History Form

Family ID: _____

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: _____

Any previous injuries or surgery? _____

Any special health-related needs of the child? _____

Any medications your child takes on a regular basis?

Parent's Signature: _____ Date: _____