HEALTH HISTORY AND MEDICAL RELEASE
(Please complete all sections and sign at bottom)

HEALTH HISTORY (Please check)

Disease	Allergies	Chronic or Recurring Illness
____ Chicken Pox	____ Hay Fiver	____ Ear Infection
____ Measles	____ Asthma	____ Heart Disease
____ German Measles	____ Drugs (specify)	____ Convulsions
____ Mumps	____ Insect Stings	____ Diabetes
	____ Ivy, Oak, etc.	____ Fainting
	____ Foods (specify)	

Does the child require regular medication? Yes____ No ____ Please specify_____

Does the child have severe allergies? Yes___ No___ If yes EPIPEN must be given to the teacher in the box with child's name.

Date of last Tetanus Shot: _____ ***MANDATORY***

Specify dietary or activity restrictions: _____

Parent/ Guardian: Received snack approved list for the Greek School. Yes___ No___

Family Physician: _____

Address: _____

Telephone: _____

Alternate Emergency Contact: _____

Address: _____

Telephone: _____

In the event that I can not be reached, I give permission for the adult in charge to take my child _____, to a qualified licensed physician or to a nearby hospital for necessary treatment.

_____

Signature of Parent/Guardian

For Office Use Only

Tuition Date Paid

Stewardship Pledge Date Paid