

GIRLS MINISTRIES HEALTH AND INFORMATION FORM

PLEASE PRINT INFORMATION CLEARLY

_____ (Year)

Child's Name: _____ Nickname: _____ DOB: _____

Address: _____

Phone Nos.: _____ (Cell) _____ (Home)

Mother's Name: _____

Address (If Different from Above): _____

Phone Nos.: _____ (Cell) _____ (Home)

Father's Name: _____

Address (If Different from Above): _____

Phone Nos.: _____ (Cell) _____ (Home)

Parent/Guardian E-Mail Address: _____

Does your child have any food or other allergies? Yes No

If yes, please explain: _____

Does your child have any physical condition that would prevent participation in regular activities? Yes No

If yes, please explain: _____

Is your child presently being treated for an illness? Yes No

If yes, please explain: _____

Is your child taking any form of medication? Yes No

If yes, please explain: _____

*****PLEASE COMPLETE FORM ON REVERSE SIDE*****

