GRACE COMMUNITY CHURCH OF THE SIERRA

YOUTH HEALTH QUESTIONNAIRE

NAME: _____

BIRTHDATE: _____ PARENT PHONE #: _____

MEDICAL ALLERGIES;

MEDICINE _____

REACTION DESCRIPTION _____

ENVIRONMENTAL ALLERGIES;

BEE STINGS, ETC… _____

REACTION DESCRIPTION _____

FOOD ALLERGIES:

NAME _____

REACTION DESCRIPTION _____

MEDICATION, INDICATE (P) PRESCRIBED OR (O) OTC, DOSAGE, FREQUENCY

P _____ O _____

P _____ O _____

O _____ O _____

SUBMIT PRINT