HEALTH & HISTORY FORM

Please Print Clearly

Name of Child:	
Date of Birth:	
Responsible Parent / Guardian:	
Physician's Name:	
Physician's Phone Number:	

Please list any medications your child is now taking and the reason for the medication:

Please indicate if your child has any of the following with a ✓:

History of heart problems	☐
High blood pressure	☐
Asthma	☐
Stroke	☐
Surgery within the last six months	☐
A chronic illness	☐
History of lung problems	☐
Diabetes	☐
History of heart problems in immediate family	☐
Allergic to any foods	☐

RALEIGH'S HOUSE OF ETIQUETTE

(If you place a check to any question please provide complete details below.)

Please list any foods that your child is allergic to in order for us to accommodate specific needs during our dining tutorial.

I hereby certify that the foregoing information is true, correct and complete.

Parent or Guardian's Name **(PRINT)** Signature

Date: ________________

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RALEIGH'S HOUSE OF ETIQUETTE