





Epilepsy			Tuberculosis			Anemia			Severe Cramps		
Asthma, Hay Fever, Hives			Hepatitis or Jaundice			Diabetes			Excessive Flow		

**Do you have any Food or drug allergies**

Food	Drug allergies

**REMARKS OR ADDITIONAL**

(Use additional sheet if necessary)

**INFORMATION**

	YES	NO
A. Do you have any disease or is any drug or other treatment being followed, which should be continued or periodically evaluated? (give details)		
B. Have you any drug or other known sensitivity or intolerance? (give details)		
C. Have you had any illness, injury, or operation or been hospitalized other than as already noted. (give details)		
D. Has your physical activity been restricted during the past five years? (give reason and duration)		
E. Have you ever been hospitalized for mental or emotional illness? (give name(s) and address(es) of doctor(s) and or hospital(s).		
F. Have you ever interrupted school or work either because of mental or emotional illness or after psychiatric consultation? (give details and doctor(s) name (s) and address(es)		

AS THE PARENT, LEGAL GUARDIAN OR AGENCY REPRESENTATIVE, I UNDERSTAND THAT SHOULD MY CHILD BE INJURED WHILE PARTICIPATING IN THIS PROGRAM, I CANNOT HOLD GIRLS INC. RESPONSIBLE AND I UNDERSTAND THAT BY PROVIDING MY SIGNATURE I WAIVE MY RIGHT TO ATTEMPT TO HOLD GIRLS INC. OF GUILFORD COUNTY RESPONSIBLE. I HAVE READ AND AGREE TO ABIDE BY ALL GUIDELINES AND POLICIES AS SET FORTH IN THE MATERIALS THAT HAVE BEEN PROVIDED FOR MY REVIEW.

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_