Medical History Form

Childs Name: _________________________ Age: _____ Date of Birth: _________

Weeks Attending: _____________________________ Gender: M______F_______

Parent/Guardian: ____

Address: ____

Home Phone #: ______________________ Work Phone #: ______________________

Cell Phone #: ______________________ E-Mail: ____________________________

Emergency Contact Information:

Name: _____________________ Relationship to Camper: ______________________

Address: ____

Phone #: ___________________________ E-Mail: ____________________________

Physician Information:

Physician: ___________________________ Office Phone #: ___________________

Family Medical/Hospital Insurance Carrier: __________________________________

Policy or Group #: ____

This health history and information is correct as far as I know. The person herein described has permission to engage in all camp activities, except as noted. In the event I cannot be reached in an emergency, I hereby give permission to medical personnel selected by the camp director to order x-rays, routine tests, to hospitalize, secure proper treatment for and to order injections or anesthesia and/or surgery for my child as named above.
I, ____, do hereby recognize the risks of illness and injury inherent during the time of the use of The Town of Hyde Park recreational facilities. Therefore, I do hereby, for myself, my heirs, executors and administrators, waive and release any and all rights and claims for damages I and/or my guests and participants may have against the Hyde Park Recreation Department, their agents, representatives, successors and assigns for any all injuries suffered by the undersigned and his/ her guests and participants during this event.

See Reverse

HEALTH HISTORY

Do you have or are subject to any of the following:

___ Asthma	___ Bee Sting Reaction
___ Bleeding Disorder	___ Diabetes
___ Fainting Spell	___ Ear Infections
___ Hay Fever	___ Heart Disease/Defect
___ Mental Condition	___ Poison Ivy Sensitive
___ Seizures	___ Sports Restriction
___ Swimming Restrictions	___ Allergies
___ Allergy or Drug Reaction	___ Dietary Restriction

Please explain any of the above: ____

If female: ______ Started Menstruation. If no, has been told about it? ____________

Provide dates of the following if you have had:

___________ Measles ___________ Mumps ___________ Chicken Pox

___________ German Measles __________ Mononucleosis __________ Diphtheria

Any operations or serious injuries:
(Include Dates) ____

Any Disability or Chronic Illness: ____

Any restriction of activity for medical reasons: ________________________________

Please list all required medication, including over the counter medications:
(Include specific dose)

Are there any medications that will need to be dispensed during camp hours? If so, please list.
You must attach a doctor's note authorizing administration by camp personnel.
Please attach to this form, the most recent immunization record for this individual.

Parent/Guardian Name (Printed): ____

Parent/Guardian Signature: ____

Date: ______/______/_____