

Town Of Hyde Park Recreation
2011 MEDICAL HISTORY FORM

Name: _____ Camp(s) Attending: _____

Age: _____ Date of Birth: _____

Parent/Guardian: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____

Emergency Contact: _____ Relationship: _____

Address: _____

Phone #: _____

Physician(s): _____

Phone #: _____

Dentist: _____

Phone #: _____

Family Medical/Hospital Insurance Carrier: _____

Policy or Group #: _____

Please Read and Sign:

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.

Signature: _____

Date: _____

HEALTH HISTORY

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

- | | |
|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bee Sting Reaction |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fainting Spell | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Heart Disease/Defect |
| <input type="checkbox"/> Mental Condition | <input type="checkbox"/> Poison Ivy Sensitive |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Sports Restriction |
| <input type="checkbox"/> Swimming Restrictions | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Allergy or Drug Reaction | <input type="checkbox"/> 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.