



DANVERS RECREATION
HEALTH FORM

This form should be filled out once per calendar year.

Name: _____ Birth Date: _____
(last) (first) (m.i.)

Age: _____ Sex: _____ Home Telephone #: _____ Cell/Beeper#: _____

Home Address: _____
(street & number) (city) (state/zip)

Parent/Guardian: _____

Work Telephone: _____

In an emergency, notify:

1) Name: _____ Telephone: _____

Address: _____ Relationship: _____

2) Name: _____ Telephone: _____

Address: _____ Relationship: _____

Is participant covered by medical insurance? _____

Carrier: _____ Policy #: _____

OPERATIONS/SERIOUS INJURIES: _____

ALLERGIES: _____

ALLERGIC REACTIONS: _____

HEALTH INFORMATION (check all that apply):

Frequent Colds/Sore Throats _____

Sinus Infections _____

Ear Infections _____

Asthma/Bronchitis _____

Fainting _____

Stomach Problems _____

Bowel/Bladder Problems _____

Heart Problems _____

Diabetes _____

Menstrual Problems _____

Epilepsy/Seizures _____

Headaches _____

Athlete's Foot _____

Motion Sickness _____

Does the participant have any health issues that may restrict him/her from participating in any recreation activities? If yes, please describe:

Details or additional information: _____

NOTE: Please notify the Program Director or designee if the child has been exposed to any communicable diseases 3 weeks prior to his/her arrival at the program.

CURRENT IMMUNIZATIONS (check all that apply or attach form):

Tuberculosis _____	Mumps _____
Chicken Pox _____	Rubella _____
Polio _____	Whooping Cough _____
Measles _____	Rheumatic Fever _____

Please also note: Any medical conditions or allergies will be shared with recreation staff to ensure the well being of your child.

PARENT/GUARDIAN Signature: _____ **DATE:** _____

Only fill out the bottom of this form if your child is on any medication!

AUTHORIZATION TO ADMINISTER MEDICATION

Medications to be taken during program hours or on an as needed basis:

Name(s): _____

Diagnosis (at parent discretion): _____

Name of medication: _____

Dosage: _____

Route of administration: _____

Frequency & time(s) to be given: _____

Side effects/Special precautions: _____

Specific directions (e.g., on empty stomach/water): _____

Special storage requirements: _____

.....
I hereby give my permission for *Danvers Recreation Staff* to administer above medication(s) to my son/daughter
(Name) _____

I understand that all medications, prescription and/or over-the-counter, must be in their original containers, must be labeled, and have specific directions for use on the label. A prescription medication must include the prescription number, medication name, date filled, child's name, doctor's name, pharmacy name, and have the expiration date noted.

PARENT/GUARDIAN: _____ **DATE:** _____