



**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: \_\_\_\_\_

Email: \_\_\_\_\_

Home Address: \_\_\_\_\_

(street & number) (city) (state/zip)

Parent/Guardian: \_\_\_\_\_

Work Telephone: \_\_\_\_\_

In an emergency, notify:

1) Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Please Note: Danvers Recreation requires all participants to have medical insurance.  
All participants must have their insurance information on file.  
Medical Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_

OPERATIONS/SERIOUS INJURIES: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

ALLERGIC REACTIONS: \_\_\_\_\_

HEALTH INFORMATION (check all that apply):

Fainting _____	Heart Problems _____
Stomach Problems _____	Diabetes _____
Bowel/Bladder Problems _____	Asthma/Bronchitis _____
Motion Sickness _____	Epilepsy/Seizures _____
	Migraines _____

**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):

Hep B 3 doses _____	Varicella 1 dose _____
DTap/DTP 5 doses _____	MMR 2 doses _____
Polio 4 doses _____	

**Please also note: Any medical conditions or allergies will be shared with recreation staff to ensure the well being of your child. If there is anything else you would like us to know about your child, please indicate at the bottom of the form.**

Health Questionnaire:

1. Are you currently under any treatment for any illness or condition? Yes No  
Describe: \_\_\_\_\_

2. Do you have a condition requiring regular medication? Yes No  
Describe: \_\_\_\_\_

3. Are you currently taking medication(s)? You are expected to have them with you during the program. (explain what each is for) Yes No  
List: \_\_\_\_\_

4. Has a medical physician told you to limit your activity in any way? Yes No  
Describe: \_\_\_\_\_

5. Have you been diagnosed with asthma? Yes No

Do you carry an inhaler or other breathing device? Yes No

6. Do you have a known allergy to any food products, medications, or insect stings? Yes No

Have you ever had an allergic anaphylactic reaction? Yes No

Do you carry Epinephrine? Yes\* No

What type? Epi Pen\* Ana Kit\*

\*You are expected to have your epinephrine with you during the program.

Additional Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If your child requires any medication during the program, you must fill out an additional form. Please request an authorization to administer medication form.

PARENT/GUARDIAN Signature: \_\_\_\_\_ DATE: \_\_\_\_\_