

YCSH Medical Form

ONE FORM PER CHILD

Childs Name

Gender

Birthdate

(One form per child)

Height

Weight

LOCAL Emergency Name & Phone #

LOCAL Emergency Name & Phone #

Child(ren)s Physician

Phone#

Health Insurance Carrier

Policy #

Group #

Insurance Phone #

Subscribers Name

Allergies:

FOOD: Yes/No If yes, please explain treatment options:

MEDICINE: Yes/No If yes, please explain treatment options:

INSECTS: Yes/No If yes, please explain treatment options:

PLANTS: Yes/No If yes, please explain treatment options:

General Information:

ADD/ADHD Yes/No

Convulsions/seizures

Yes/No

Diabetes/hypoglycemia

Yes/No

Hemophilia Yes/No

Asthma

Yes/No

Heart Trouble

Yes/No

Bee Sting Allergy Yes/No

Anxieties/fears

Yes/No

EpiPen

Yes/No

Epilepsy Yes/No

Major operations

Yes/No

Other

Explain any "YES"

List any medications your child will be taking during the summer

Are there any activity restrictions?

Eyeglasses Yes/No

Contacts

Yes/No

Hearing Problems

Yes/No

The information provided is correct and accurate to the best of my knowledge. I give permission for full participation in YCSH YAP, subject to limitations noted herein. In case of emergency, I understand every effort will be made to contact me. In the event that I can not be reached, I hereby give my permission to the licensed health-care practitioner selected by the Director or designee to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

Signature of Parent/Guardian

Date