HEALTH HISTORY FORM

CHILD'S NAME: _____D.O.B._____MALE____FEMALE____

ADDRESS: _____

(*Insert dates of immunizations*)

IMMUNIZATION RECORD:

(DPT) #1_____#2_____#3_____#4_____
(HIB) Haemophillis B #1_____#2_____#3_____#4_____
POLIO (OPV) #1_____#2_____#3_____#4_____
VARICELLA _____

(HEP B) HEPATITIS B #1_____#2_____#3_____
(TB) TUBERCULIN (+ -)_____
(MMR) MEASLES, MUMPS, RUBELLA_____
INFLUENZA _____

List any known allergies (including food and/or drug):_____

_____

Does the camper have any dietary restrictions?_____

_____

List ALL medication camper uses on a regular basis: _____

_____

Is camper subject to seizures? Yes____No____If yes, please explain: _____

_____

Does camper have any physical conditions which may limit his/her participation in sports or other activities?

Yes_____No_____If yes, explain:_____

_____

May camper participate in a recreational swim program? Yes_____No_____If no, explain: _____

_____

Please list any additional information you feel we should know in order to better serve your child: _____

Doctor's Name: _____Address: _____

MEDICAL WAIVER: The staff of KIDSPORTS will take responsible measures to supervise the children's daily activities. In the event of an extreme emergency, an ambulance will be called.

I give my child permission to participate in all KIDSPORTS activities.

I authorize my child to be taken to RARITAN BAY HOSPITAL for emergency medical care.
I WILL ASSUME FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED by the medical center.

Child's Medical Carrier Number: _____Medical Carrier Name: _____

Parent's Signature: _____Date: _____