COMMUNITY RECREATION HEALTH FORM

Children's Specialized Hospital

FORM DATE: _____ DATE OF BIRTH: _____

CHILD'S NAME: _____ GUARDIAN NAME: _____

ADDRESS: _____

EMERGENCY CONTACT & PHONE: _____

EMERGENCY CONTACT 2 & PHONE: _____

PHYSICIAN: _____ PHONE: _____

DENTIST: _____ PHONE: _____

INSURANCE COMPANY: _____ POLICY NUMBER: _____

CHILD'S DIAGNOSIS: _____

HISTORY OF SEIZURES? ☐ YES ☐ NO ALLERGIES: _____
(Please complete an additional action plan form if your child has seizures/asthma/allergies)

CHILD IMMUNICATIONS UP TO DATE: ☐ YES ☐ NO

Please explain any known restrictions for activities, other precautions, health, or medical issues that our staff should be aware of: _____

_____

_____

PARENT/GUARDIAN ASSISTANCE:
I acknowledge that I will accompany my child in activities in the event that the scheduled volunteers are unable to attend.

_____
SIGNATURE OF PARENT/GUARDIAN DATE

IN CASE OF EMERGENCY: I certify that the above information is accurate & my child does not have any health or medical issues that would prohibit him/her from participating in these community programs. Permission is given to Children's Specialized Hospital or its representatives to provide or seek medical care in case of emergency for the above person.

_____
SIGNATURE OF PARENT/GUARDIAN DATE

_____
SIGNATURE OF PHYSICIAN DATE

_____
Name of Physician and Practice

Please note that this form must be updated by parents/caregivers annually or when information changes. Updated 10/21/16