

# HEALTH HISTORY FORM

CHILD'S NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

ADDRESS: \_\_\_\_\_

(\*Insert dates of immunizations\*)

## IMMUNIZATION RECORD:

(DPT) #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

(HIB) Haemophilus 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: \_\_\_\_\_

