

HEALTH HISTORY FORM

CHILD'S NAME: _____ D.O.B. _____ MALE _____ FEMALE _____

ADDRESS: _____

Insert dates of immunizations

IMMUNIZATION RECORD:

(DPT)	#1	#2	#3	#4	(HEP B) HEPATITIS B	#1	#2	#3
(HIB) Haemophilis B	#1	#2	#3	#4	(TB) TUBERCULIN (+ -)	_____		
POLIO (OPV)	#1	#2	#3	#4	(MMR) MEASLES, MUMPS, RUBELLA	_____		
VARICELLA	_____							

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: _____

