

Hilton-Parma Recreation Department
INFORMATIONAL PLAYGROUND MEDICAL FORM

Appendix B

Child's Name: _____ Date of Birth: _____ Age: _____

Male: ___ Female: ___ My child has permission to: ___ walk ___ bike to/from playground

Parent/Guardian: _____ Home Phone #: _____

Home Address: _____ City: _____ Zip: _____

Cell Phone #: Mom: _____ Dad: _____

Work Phone #: Mom: _____ Dad: _____

In Case of EMERGENCY:

1ST Contact: _____ Relationship: _____ Phone #: _____

2nd Contact: _____ Relationship: _____ Phone #: _____

Health History: Respond with "Y" (for yes) and "N" (for no); please give date of diagnosis and current management below, if appropriate.

- _____ Vision Impairment
- _____ Hearing Impairment
- _____ Frequent Ear Infections
- _____ Heart Defect/Disease
- _____ Diabetes
- _____ Convulsions/Seizures
- _____ Asthma
- _____ High Blood Pressure
- _____ Lung Disease
- _____ Bleeding/Clotting Disorder
- _____ Kidney Disease
- _____ Cancer

- Allergies**
- _____ Hay Fever
 - _____ Poison Ivy, etc.
 - _____ Penicillin
 - _____ Insect Stings

- Diseases**
- _____ Chicken Pox
 - _____ Measles
 - _____ Shingles
 - _____ German Measles
 - _____ Mumps

Further Details of a "Yes" answer: _____

Physical Limitations: _____

Is child allergic to any food, or medications/drugs other than those shown above?

List any/all Medications child is currently taking:

Is child on a special diet? If so, explain:

Should child be restricted in recreation or swimming?

Has child been under any medical care within the past three months? If so, explain:

Mental and/or emotional growth normal for child's age?

Anything else we should know about your child?

MEDICAL FORM (continued)

Child's Name: _____

IMMUNIZATION HISTORY - To be filled in by doctor, school nurse or parent. Form from Dr.'s office can be stapled.

To your knowledge, are all shots up to date and meet the NYS Health requirements? Yes No

The NYS Dept. of Health requires an immunization history to be kept on file for each camper.

Please notify camp if child is exposed to any communicable disease during the 3 weeks prior to camp (especially chicken pox or shingles).

DPT (diphtheria, pertussis, & tetanus)	1 ST	2 ND	3 RD	Booster	Booster
POLIO (ORAL)	1 ST	2 ND	3 RD	Booster	Booster
MEASLES* (red/hard)	Date	RUBELLA*	Date	MUMPS*	Date
VARICELLA (Chicken Pox)	Date	Booster	Booster		
HIB (Hemophilus Influenza Type B)	1 ST	2 ND	3 RD	Booster	
HB (Hepatitis B)	1 ST	2 ND	3 RD	Tuberculin Test Given?	Y N Date:

*MMR (Measles, Mumps Rubella) triple vaccine is usually given together.

If above information was completed by a Physician or School Nurse, please provide signature:

Name: _____ Signature: _____ Date: _____

Name of Dentist: _____ Phone #: _____

Name of Orthodontist: _____ Phone #: _____

Name of Primary Care Physician: _____ Phone #: _____

Do you carry family medical/hospital insurance? Yes No

If yes, Carrier: _____ Policy or Group #: _____

Consent for Medical Treatment

The Town of Parma does not provide medical insurance. This health history is correct as far as I know. I give permission for the above named child to participate in all prescribed camp activities except as noted. I also give permission for the above child to be given first aid in case of emergency. This includes permission for the participant to be taken to the Emergency Department of a local hospital and for a licensed physician or other hospital staff to carry out care deemed necessary. I understand that I will be notified as soon as possible. I hereby waive and release The Town of Parma, Hilton-Parma Recreation and its employees of any liabilities or claims in association with anything that might occur while my child is attending our Summer Playground.

Parent/Guardian Signature: _____ Date: _____