HAMPDEN MEMORIAL PARK HEALTH FORM

Name: _____
Age: _____ D.O.B_____
Parent/Guardian: _____Phone: _____
Address:
_____
Family Doctor: _____Phone: _____
Address: _____City/State: _____

HAVE OR SUBJECT TO (CHECK IF YES)
____Asthma ____Inhaler ____Fainting Spells ____Convulsions ____Diabetes
____Heart trouble ____Bee sting reaction ____Epi-pen _____ADD/ADHD

Sports Restrictions (describe)
_____
Other Restrictions (describe)
_____
Allergy/Reaction to any medications or foods (describe)
_____
____Check here if none apply
HAVE DIFFICULTY WITH (CHECK IF YES)
___Eyes ___Ears ___Nose ___Digestion ___Throat ___Lungs

ANY CONDITION REQUIRING REGULAR MEDICATION:
Name of medication:
_____
Check if had:
___Measles ___Chicken pox ___German measles ___Diphtheria ___Whooping cough ___Mumps

RESTRICTIONS OF ACTIVITY FOR MEDICAL REASONS:
_____

IMMUNIZATIONS: Please fill in DATE of last inoculation-DO NOT WRITE- "up to date"
Tetanus Toxoid: ___/____ Measles: ___/____ Polio: ___/____ Mumps: ___/____
German Measles: ___/____ Diphtheria___/____ Pertussis: ___/___
Date of last physical exam: _____
(must be within 1 year of camp attendance)

PHYSICIANS SIGNATURE: _____

PARENT'S AUTHORIZATION:
This health history is correct to the best of my knowledge. My child has permission to participate in all activities, except as noted by me above. In the event that I cannot be reached in an emergency, I hereby give permission to the physician, selected by the Recreation Department, to provide emergency treatment to my child.

_____
(Parent's Signature) (Date)