

Medical History Form 2020

Medical History Form

Please provide information in relation to any health conditions, behavioral concerns, dietary needs, medication or special needs. All health-related information will remain confidential, except in emergency situations. Park District staff is not authorized to dispense any medication.

Participant Name (Required): _____

Parent/Guardian Name (Required): _____

Phone where guardian can be reached in an emergency: () - _____

List all medications prescribed or taken regularly (Required):

If none, type N/A

Health Concerns; check all that apply (Required - Select at least one option):

- Allergies Asthma
 Fainting Inhaler
 Seizures N/A
 Other

If Other, please explain: _____

Please provide further details would help counselors regarding any health concerns checked above:

List all Allergies and reactions (Required):

*Example 1: Peanut allergy only when ingested not inhaled - Body rash and tongue swelling.
Example 2: Poison Ivy - minor rash. If no allergies please type N/A.*

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List any dietary restrictions (Required):

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I will be leaving an epinephrine auto-injector at the program (Required - Select at least one option):

Yes**

No

**If you will be leaving epinephrine for your child, you are required to fill out this

Detail any emotional, behavioral or physical disabilities staff should be aware of to improve the participant's experience (Required):

Such as ADD, ADHD, Autism, PTSD, use of braces/canes/walkers/wheelchairs. If none please type N/A

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