DANVERS RECREATION HEALTH FORM

This form shall be filled out once per calendar year.

Name: _____Birth Date: _____
(Last) (First) (M.I.)
Age: _____ Sex: _____ Home Telephone #:_____Cell:_____

Program(s) attending: _____

Email: _____

Home Address: _____
(Street & number) (City) (State/Zip)
Parent/Guardian: _____

Work Telephone: _____

Please indicate which Program/Weeks: _____
_____

In case of emergency please notify:
Name: _____Telephone:_____

Address: _____Relationship: _____

Please Note: Danvers Recreation requires all participants to have medical insurance.
All participants must have their insurance information on file.
Medical Insurance Company: _____
Policy Number: _____

OPERATIONS/SERIOUS INJURIES: _____
_____

ALLERGIES: _____

ALLERGIC REACTIONS: _____

HEALTH INFORMATION (check all that apply):

Fainting/Dizziness_____	Heart Problems_____
Stomach Problems_____	Diabetes_____
Bowel/Bladder Problems_____	Asthma/Bronchitis_____
Motion Sickness_____	Epilepsy/Seizures_____
Migraines_____	Wear glasses, contacts or protective eyewear_____
Ever had back/joint problems_____	Passed out/had chest pain during exercise_____

NOTE: Please notify the Program Director or designee if the child has been exposed to any communicable diseases 3 weeks prior to his/her arrival at the program.

CURRENT IMMUNIZATIONS (please fill in and attach form):

Immunization	Dose 1 MM/YYYY	Dose 2 MM/YYYY	Dose 3 MM/YYYY	Dose 4 MM/YYYY	Dose 5 MM/YYYY	Most Recent MM/YYYY
Diptheria, tetanus, pertussis DTaP/TdaP						
Tetanus Booster dT/TdaP						
Hepatitis B						
Polio (IPV)						
Varicella ☐ Had chicken pox (chicken Pox) Date:						
Measles, Mumps and Rubella (MMR)						

Please also note: Any medical conditions or allergies will be shared with recreation staff to ensure the well being of your child. If there is anything else you would like us to know about your child, please indicate at the bottom of the form.

Health Questionnaire:

1. Are you currently under any treatment for any illness or condition? Yes No
Describe:_____
_____

2. Do you have a condition requiring regular medication? Yes No
Describe:_____
_____

3. Are you currently taking medication(s)? You are expected to have them with you during the program. (Explain what each is for) Yes No
If yes, you must fill out a separate consent for administration form.
List:_____
_____

4. Has a medical physician told you to limit your activity in any way? Yes No
Describe:_____
_____

5. Have you been diagnosed with asthma? Yes No

6. Do you carry an inhaler or other breathing device? Yes No

7. Any known allergies to any food products, medications, or insect stings? Yes No

8. Have you ever had an allergic anaphylactic reaction? Yes No

9. Do you carry Epinephrine? Yes* No

9a. If yes, what type? Epi Pen* Ana Kit*

***You are expected to have your epinephrine with you during the program. Parent or guardian must sign consent for administration.**

Additional
Information:_____
_____
_____
_____

If your child requires any medication during the program, you must fill out an additional form. Please request an authorization to administer medication form.

PARENT/GUARDIAN Signature: _____DATE:_____

Rev on April 7, 2015
Supersedes previous health forms