Camper's Name:	Camp Name:	Parent/Guardian Primary Phone #:

Health History Form

Child Information

Preferred Name:		Date of Birth:	Gender: ☐ Male ☐ Female
First Name:	Middle Name:	Last Name:	
Name of Parent(s)/Guardian(s) with whom child currently resides:			

Parent/Guardian Information

1 First Name:	Middle Name:	Last Name:
Relationship to Child:	Home Address:	Home Phone:
Cell Phone:	Work Address:	Work Phone:
Email Address:		

2 First Name:	Middle Name:	Last Name:
Relationship to Child:	Home Address:	Home Phone:
Cell Phone:	Work Address:	Work Phone:
Email Address:		

The child will be released only to the person signing this form or to the following persons:

Emergency Contact First Name:	Last Name:
Relationship to Child:	Home Phone:
Work Phone:	Cell Phone:

Authorized Pick-up First Name:	Last Name:
Relationship to Child:	Home Phone:
Work Phone:	Cell Phone:

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Health History Form Continued...

Physician Information

Name of Family Physician:	Phone:
Office Address:	Date of Last Physical Examination:
Name of Dentist/Orthodontist:	Phone:
Office Address:	

Insurance Information

Is your child covered by medical/hospital insurance? ☐ Yes ☐ No	Insurance Provider Name:
Policy Number:	Group/ID:
Name of Insured:	Relationship to Child:

Immunization Information

Please record the month and year of your child's immunizations. If you do not know the dates or whether the child had a certain immunization, simply leave blank.

DPT *(Diphtheria, Pertussis, Tetanus)*	HIB *(Haemophilus Influenza B)*	Tuberculin Test	Tetanus Booster
Polio	Varicella *(Chicken Pox)*	Hepatitis B	Hepatitis A
MMR *(Measles, Mumps, Rubella)*	Rotavirus	Pneumococcal-7	Meningococcal

Communication Information

Does your child communicate verbally? ☐ YES ☐ NO ☐ LIMITED
If you answered NO or LIMITED, please describe how your child prefers to communicate and list any special communication instructions for staff members. Please feel free to use a separate sheet of paper.

Allergy Information

If your child is allergic to any medicines, foods or other substances, please list them below. Additionally, please list your child's reaction to such allergens, and the names and dosages of any medications your child's doctor has recommended or prescribed to treat your child's allergies or reactions to the same.

Allergen	Reaction	Medication/Instructions

Health History Form Continued...

Health History Information

Circle any of the following conditions that your child has experienced in the past or is currently experiencing.

Asthma	Chicken Pox	Chronic/Recurring Illness	Heart Defect/Heart Disease	Mononucleosis
Diabetes	Hypertension	Bone Fractures	Bleeding/Clotting Disorder	Measles/German Measles
Sinusitis	Skin Condition	Emotional Disability	Frequent Ear Infections	Hepatitis
Bronchitis	Eating Disorder	Operations	Emotional Disability	Joint Problems
Fainting/Dizziness	Physical Disability	Serious Injuries	Wears Glasses/Contacts	Mumps
ADD/ADHD	Deaf/Hard of Hearing	Seizures, Epilepsy, Convulsions	Frequent Cold/Sore Throat	Communication Disorder
Stomach Aches	Psychiatric Counseling	Constipation/Diarrhea	Frequent Headaches	Autism Spectrum
Recent Infectious Disease	Hospitalization	Urinary Tract Infections	Tuberculosis	

Other *(please explain)*:

Mental, Emotional, and Social Health Information

If your child is experiencing any of the following conditions or circumstances, please provide us with any special instructions or care that you would like camp or program staff to follow in light of your child's needs. Feel free to use a separate sheet of paper.

Attention Deficit Disorder (ADD) or ADHD:
Psychiatric diagnosis, i.e. depression, OCD, panic/anxiety disorder:
Emotional health concerns:
Mental health concerns:
A significant life event that continues to affect the child's life, i.e. a death in the family, new sibling, family change, adoption or foster care arrangement, survival of a disaster:

Swimming Ability

My child is: ☐ UNABLE TO SWIM	My child is: ☐ ABLE TO SWIM
The above named child does not have my permission to participate in swimming or water activities in the main pool and must be restricted to the zero-depth pool only.	I give my permission to Kettering Camp Staff to designate pool boundaries for the above named child after a swim test has been administered.

Additional Health Information

Please note campers are responsible for applying their own sunscreen and bug repellent.

Please include any additional information that you feel is important for camp or program staff to know about your child's physical, emotional, or mental health; your child's diet; or your child's physical capabilities or restrictions. Please feel free to attach additional pages, if necessary. ☐ No further information.

Health History Form Continued...

Parent/Guardian Authorization

IMPORTANT — THIS BOX MUST BE COMPLETED FOR ATTENDANCE

The information I have provided in this form is true and accurate to the best of my knowledge. I have indicated all special health conditions, including any medications required to be administered to my child, and any activity limitations, which should be communicated to camp, program, or medical personnel. I accept the risk inherent in the camp or program activities in which my child will participate. Thus, the child herein described has my permission to engage in all camp or program activities except as specifically noted in this form. Also, in the event emergency medical or dental care is determined necessary for my child by camp or program staff, I give my permission to the necessary individuals to transport my child to the hospital or clinic indicated below or to the nearest available source of assistance. Also, in the event I cannot be reached, I give my permission to the physician, selected by the camp or program director, to secure or administer treatment, including hospitalization for my child. I agree to the release of any records necessary for treatment, referral, billing, or for insurance purposes. I absolve the City of Kettering and all of its elected officials, employees, representatives, agents, and volunteers of any and all liability, financial or otherwise, arising from administration of treatment or medication to my child in accordance with the information I've provided in this form. The City of Kettering shall not be held responsible for payment of any medical expenses incurred during my child's participation in any City of Kettering camp or program. These forms may be photocopied for field trips. The indemnifications, permissions, releases, and authorizations that I have provided in this and any other camp or program forms, including the registration forms, are binding on me personally and on my heirs, personal representatives, successors, and assigns. This authorization and all camp or program forms shall be governed by the laws of the State of Ohio, Montgomery County. By signing below you acknowledge that you are the legal guardian of the child specified and that you have legal authority to make the decisions and provide the authorizations required in this and all other necessary camp or program forms on behalf of the child.

____ ____

Name and address of preferred hospital or medical clinic — Name and address of preferred dental clinic

____ ________________________

Parent/Guardian Signature — Date

____ ________________________

Parent/Guardian Signature — Date

Permission to Transport Child to Extended Care

(Complete Part 1 or Part 2)

Part 1: Permission Granted

In the event my child is unable to be picked up immediately following the camp or program day, Kettering PRCA Staff has permission to transport my child to and from my child's PRCA camp location for the purpose of extended care at the Kettering Recreation Complex.

____ ________________________

Parent/Guardian Signature — Date

Part 2: Permission Denied

My child is not permitted to be transported from my child's PRCA camp location for purposes of extended care, unless I am late for pick up as explained in the paragraph below. Instead, I have arranged for my child to be picked up by any of the following individuals (please provide phone numbers of each individual listed). Also, please indicate whether your child is permitted to walk home unaccompanied:

____

____

____ ________________________

Parent/Guardian Signature — Date

IN THE EVENT YOU ARE LATE FOR PICK UP: On camp or program days, parents or guardians must pick up their children by 4:00 p.m. from any Kettering PRCA program. The necessary PRCA staff is not available to wait with children whose parents or guardians are late to pick them up from camp or program activities. If a parent or guardian does not arrive by 4:00 p.m., PRCA staff will transport the child to extended care at Kettering Recreation Complex and the child's parent or guardian will be charged a fee for such care. By allowing your child to participate in camp or program activities, you agree that Kettering PRCA staff may transport your child to the Kettering Recreation Complex for extended care in the event you or the child's assigned caregiver is late, and you agree further that you will pay the costs incurred related to extended care.

Request for Administration of Medication

Section I: Physician's Instructions

Section I does not need to be completed for certain non-prescription items, such as: fever-reducing medicines that do not contain aspirin; cough or cold medications that do not contain codeine; and topical ointments, creams, or lotions.

(Name of Child) ______________________________ is under my care and should receive

(name of medicine, vitamin, or modified diet) ______________________________

(dosage) ______________ as follows ______________________________

Specific instructions for administration: ______________________________

Possible side effects: ______________________________

Expiration date *(may not exceed six months from date of this request if prescribing medication or food supplement)*: ______________

______________________________ ______________ ______________
Physician Signature Date Phone Number

NOTE: If a medication or vitamin is provided to your child by use of a prescription from a pharmacy, a physician's instructions and signature are not necessary to include on this form. Instead of completing Section I above, please fill out the following blanks.

Rx Number: ______________________ Pharmacy: ______________________

Pharmacy Address: ______________________ Phone Number: ______________

Section II: PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICINE, VITAMIN, FOOD SUPPLEMENT OR MODIFIED DIET

I request and give permission to the administrator or his/her delegate to administer the following medication, vitamin, or special diet to my child:

Note: All medication must be in original container with proper dosage and time instructions clearly marked. No more than one week's supply will be accepted and stored by the camp or program staff.

Name of Child	Name of Item to be Administered	Dosage	Times of Dosage

______________________________ ______________
Parent/Guardian Signature Date

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