

2010 MEDICAL HEALTH HISTORY

THIS SIDE TO BE COMPLETED BY Parent/Guardian

To be completed for every child attending the YWCA programs

A Medical Health History form MUST be on file for every child attending the YWCA programs.

Child Name _____ Female _____ Male _____ Birthdate ____/____/____ Age _____
Home Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ - _____

In case of an emergency, and the *YWCA of Niagara* is unable to reach the parent/guardian listed above, the following individual(s) have permission to make decisions regarding the care of my child, including permission to pick up my child from the YWCA in case of an emergency or dismissal from the *YWCA of Niagara*.

Name _____ Relationship to child/staff _____
Address _____ City/State/Zip _____
Home Phone (____) _____ Work Phone (____) _____

PARENTS: If you will be away from home during your child's time with us, please attach a separate sheet of paper with all the relevant information (hotels/phone numbers/itineraries/etc.).

ARE YOU COVERED BY ANY HOSPITALIZATION/MEDICAL CARE POLICY? YES _____ NO _____
Name of Primary Insurance Company _____ Phone #(____) _____
Address _____
Policyholder's Name _____ Policyholder's Social Security #: _____
Policyholder's Birthdate: _____ Policy # (including 3 letters): _____
Is policy through employer? ____yes ____no

PARENT/GUARDIAN AUTHORIZATION To the best of my knowledge this health history is correct and the designated child may engage in all YWCA activities (except where noted by the examining physician or myself). I authorize the YWCA staff to supervise self-administration of sunscreen products by my child following the specific orders and guidelines of the child's physician. In an emergency I authorize the YWCA Program Director to act for my child according to her/his best judgment where medical or surgical treatment is required. I accept responsibility for all medical bills resulting from the illness or injury while my child is in the care of the YWCA.

PARENT/GUARDIAN SIGNATURE

DATE

HEALTH HISTORY – Indicate illness dates, if possible and explain as necessary.

Chicken Pox _____	Convulsions _____	Allergies:	
Measles _____	ADD/ADHD _____	Peanut _____	Penicillin _____
Mumps _____	OCD/ODD _____	Milk _____	Insect Bites _____
Asthma _____	Autism _____	Lactose Intolerant _____	Other: _____
Diabetes _____	Aspergers _____	Bee Sting _____	
Hearing _____	Emotional/Psychological _____	Grass _____	
Vision _____			

Other diseases or details of above _____

Dates of operations or serious injuries/illness _____

Chronic or recurring illness _____

Is the child/staff currently taking any prescribed medications? ____yes ____no. Please be sure to consult with your physician about bringing these medications to the YWCA of Niagara.

Name of Dentist _____ Phone # _____

Name of Pediatrician _____ Phone # _____