

# 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  Fainting Spells  Convulsions  Diabetes

Heart trouble  Bee sting reaction  ADD/ADHD

Sports Restrictions (describe) \_\_\_\_\_

Other Restrictions (describe) \_\_\_\_\_

Allergy/Reaction to any medications (describe) \_\_\_\_\_

Check here if none apply

## HAVE DIFFICULTY WITH (CHECK IF YES)

Eyes  Ears  Nose  Digestion  Throat  Lungs

## ANY CONDITION NOW REQUIRING REGULAR MEDICATION?

Name of medication: \_\_\_\_\_

Check if had:

Measles  Chicken pox  German measles  Diphtheria  Whooping cough  Mumps

## RESTRICTIONS OF ACTIVITY FOR MEDICAL REASONS

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**IMMUNIZATIONS:** Please fill in DATE of last inoculation-**DO NOT WRITE**- "up to date"

Tetanus Toxoid: \_\_\_/\_\_\_ Measles: \_\_\_/\_\_\_ Polio: \_\_\_/\_\_\_ Mumps: \_\_\_/\_\_\_

German Measles: \_\_\_/\_\_\_ Diphtheria \_\_\_/\_\_\_ Pertussis: \_\_\_/\_\_\_

**PHYSICIANS SIGNATURE:** \_\_\_\_\_

## PARENT'S AUTHORIZATION:

This health history is correct so far as I know. 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.

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(Parent's signature)

(Date)