HEALTH RECORD FORM – TO BE COMPLETED BY PARENT

CHILD'S NAME_____AGE_____DATE OF BIRTH___/__/___
(Last) **(First)**

ADDRESS_____HOME PHONE_____

MOTHER'S NAME_____WORK PHONE_____CELL#_____

FATHER'S NAME_____WORK PHONE_____CELL#_____

IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY: NAME_____

RELATIONSHIP TO CHILD_____

NAME OF PHYSICIAN_____PHONE_____

NAME OF DENTIST/ORTHODONTIST_____PHONE_____

HEALTH HISTORY AND WELFARE CONSIDERATIONS

ARE THERE ANY ALLERGIES TO FOODS, MEDICATIONS, INSECT STINGS, ETC?_____

_____

_____

ANY DIETARY ISSUES?_____

DOES YOUR CHILD RECEIVE ANY MEDICATIONS?_____

ANY SUPPORT SERVICES?_____

DOES YOUR CHILD HAVE ANY EMOTIONAL, SOCIAL OR BEHAVIORAL DIFFICULTIES?_____
_____

ANY PHYSICAL LIMITATIONS OR RESTRICTIONS?_____
_____

DO YOU HAVE ANY SUGGESTIONS OR SPECIAL INSTRUCTIONS FOR YOUR CHILD'S CARE?
_____

_____

I hereby give permission for my child to take trips, including overnight trips, with his/her group during the coming season. I also hereby authorize RUACH DAY CAMP to provide routine medical care and to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible. This form may by photocopied for use out of camp. In the event that I cannot be reached by phone in an emergency, I hereby give permission to my family physician any local physician or hospital and to RUACH DAY CAMP to administer emergency treatment to my child.

_____ _____
Parent's Signature Date