

**Hilton-Parma Recreation Department**  
**INFORMATIONAL PLAYGROUND MEDICAL FORM**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Male: \_\_\_ Female: \_\_\_ My child has permission to: \_\_\_ walk to/from playground \_\_\_ bike to/from playground

Parent/Guardian: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone #: Mom: \_\_\_\_\_ Dad: \_\_\_\_\_

Work Phone #: Mom: \_\_\_\_\_ Dad: \_\_\_\_\_

**In Case of EMERGENCY:**

1<sup>ST</sup> Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

2<sup>nd</sup> Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Health History:** Respond with "Y" (for yes) and "N" (for no); please give date of diagnosis and current management below, if appropriate.

- \_\_\_\_\_ Vision Impairment
- \_\_\_\_\_ Hearing Impairment
- \_\_\_\_\_ Frequent Ear Infections
- \_\_\_\_\_ Heart Defect/Disease
- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Convulsions/Seizures
- \_\_\_\_\_ Asthma
- \_\_\_\_\_ High Blood Pressure
- \_\_\_\_\_ Lung Disease
- \_\_\_\_\_ Bleeding/Clotting Disorder
- \_\_\_\_\_ Kidney Disease
- \_\_\_\_\_ Cancer

Allergies

- \_\_\_\_\_ Hay Fever
- \_\_\_\_\_ Poison Ivy, etc.
- \_\_\_\_\_ Penicillin
- \_\_\_\_\_ Insect Stings

Diseases

- \_\_\_\_\_ Chicken Pox
- \_\_\_\_\_ Measles
- \_\_\_\_\_ Shingles
- \_\_\_\_\_ German Measles
- \_\_\_\_\_ Mumps

Further Details of a "Yes" answer: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physical Limitations: \_\_\_\_\_

Is child allergic to any food, or medications/drugs other than those shown above?

\_\_\_\_\_

List any/all Medications child is currently taking:

\_\_\_\_\_

Is child on a special diet? If so, explain:

\_\_\_\_\_

Should child be restricted in recreation or swimming?

\_\_\_\_\_

Has child been under any medical care within the past three months? If so, explain:

\_\_\_\_\_

Mental and/or emotional growth normal for child's age?

\_\_\_\_\_

Anything else we should know about your child?

\_\_\_\_\_

**MEDICAL FORM (continued)**

Child's Name: \_\_\_\_\_

**IMMUNIZATION HISTORY** - To be filled in by doctor, school nurse or parent or immunization chart from Dr.'s office can be stapled to this.

To your knowledge, are all shots up to date and meet the NYS Health requirements? Yes No

The NYS Dept. of Health requires an immunization history to be kept on file for each camper.  
*Please notify camp if child is exposed to any communicable disease during the 3 weeks prior to camp (especially chicken pox or shingles).*

<b>DPT</b> (diphtheria, pertussis, & tetanus)	1 <sup>ST</sup>	2 <sup>ND</sup>	3 <sup>RD</sup>	Booster	Booster
<b>POLIO</b> (ORAL)	1 <sup>ST</sup>	2 <sup>ND</sup>	3 <sup>RD</sup>	Booster	Booster
<b>MEASLES*</b> (red/hard)	Date	<b>RUBELLA*</b>	Date	<b>MUMPS*</b>	Date
<b>VARICELLA (Chicken Pox)</b>	Date	Booster	Booster		
<b>HIB</b> (Hemophilus Influenza Type B)	1 <sup>ST</sup>	2 <sup>ND</sup>	3 <sup>RD</sup>	Booster	
<b>HB</b> (Hepatitis B)	1 <sup>ST</sup>	2 <sup>ND</sup>	3 <sup>RD</sup>	<b>Tuberculin Test Given?</b>	Y N Date:

\*MMR (Measles, Mumps Rubella) triple vaccine is usually given together.

If above information was completed by a Physician or School Nurse, please provide signature:

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Orthodontist: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Do you carry family medical/hospital insurance? Yes No Name of Policy Holder \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy or Group #: \_\_\_\_\_

**Consent for Medical Treatment**

The Town of Parma does not provide medical insurance. This health history is correct as far as I know. I give permission for the above named child to participate in all prescribed camp activities except as noted. I also give permission for the above child to be given first aid in case of emergency. This includes permission for the participant to be taken to the Emergency Department of a local hospital and for a licensed physician or other hospital staff to carry out care deemed necessary. I understand that I will be notified as soon as possible. I hereby waive and release The Town of Parma, Hilton-Parma Recreation and its employees of any liabilities or claims in association with anything that might occur while my child is attending our Summer Playground.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_