

Randolph Recreation Health History Form

Participants Name: _____ Age: ____ Sex: ____ Birth Date: _____

Address: _____ Town: _____ Zip Code: _____

Parent/Guardian Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Medical Insurance Carrier: _____

Policy #: _____ Subscriber Name: _____

Restrictions/Limitations

Does your child have any physical restrictions that would not allow him/her to participate in athletics?

Does your child have any allergies to food, bee stings, medication, latex, hay-fever or asthma?

Please provide a description of the physical reaction your child would experience if exposed to his/her allergen?

Medication Policy

- Any medication sent with your child must be a prescription.
- All medication must be in the original container with the name of the person to whom it was prescribed on the label.
- The medication must also contain the doctor's name, prescription date, expiration date and name of the prescription clearly marked on the label.
- All medication will be given according to the label directions unless otherwise specified in writing by the prescribing physician.
- All medication will be stored in a locked box at your child's program site and dispensed only by the site director.
- Do not send non-prescription, over the counter medication, lotions or creams with your child to the recreation program without a written note from his/her physician.

Parental Consent

I affirm that this history is correct and that my child has permission to engage in all recreation activities except as noted under "Restrictions/Limitations". I hereby give permission for the site director to administer basic first aid and/or to secure proper medical treatment on behalf of my child:

Signature of Parent/Guardian: _____ Date: _____