Town of Sandwich
Recreation Department

Super Fun Summer Program

Medical Form

General Information

Child's Name _____ D.O.B. _____Gender _____ Age_____

Participant's Summer Address:_____

Mother's/Guardian 1:
Full Name: _____

Relationship to child:_____

Home Phone #_____

Work Phone #_____

Cell Phone # _____

Father's/Guardian 2:
Full Name: _____

Relationship to child:_____

Home Phone # _____

Work Phone # _____

Cell Phone # _____

In the event that a Parent or/and Guardian cannot be reached please list two additional contacts:

Emergency Contact #1_____Phone(H)_____ Phone(W)_____
Relationship_____

Emergency Contact #2_____Phone(H)_____ Phone(W)_____
Relationship_____

Do you carry family medical/hospital insurance? NO YES if yes, please indicate:

Carrier:_____Policy/Group#_____

If the parent/guardian or emergency contact cannot be reached, is permission granted to the Program Director/Nurse for emergency treatment to be given? YES NO

If necessary, is permission granted to the Program Director/Nurse for your child to be taken to the hospital?
YES NO

Child's Name _____D.O.B. _____Gender _____ Age_____

Physician Information

Name of Physician: _____ Phone #_____

Name of Dentist/Orthodontist: _____ Phone #_____

Medication Information

Is your child on any medication? NO YES
If yes, please complete the following:

Diagnosis	Physician	Medication	Dosage/Time

How is medication given? _____

Additional information:
_____

Medical History

In order to better serve your child, please indicate in detail any needs, disabilities, or concerns that your child has (include hearing aids, glasses, contacts, braces, wheelchair, etc.):
_____
_____
_____

Does your child have difficulty in any of the following areas? (Please circle any/all that apply.)

Neurological Orthopedic Hearing Vision Motor Impairment

Additional information:_____

Allergies

Food (please list and describe reaction):_____

Medication(s): _____

Other (please list):_____

Child's Name _____ D.O.B. _____ Gender _____ Age_____

Behavioral

Does your child have any behavioral difficulties? NO YES (Please circle any/all that apply.)

Hitting Pinching Kicking Tantrums Non-Compliant Biting Hyperactivity

Screaming ADD ADHD Task Refusal Running Away Short attention span

Self-stimulation Crying

Additional information:

_____

_____

Is your child currently on a behavior modification plan at school? NO YES

Name of your child's school:_____ Teacher's name: _____

Is your child currently on a behavior modification plan at home? NO YES

Toileting

Does your child need any assistance in toileting? NO YES

Additional information:_____

Eating

Does your child need any assistance in eating? NO YES

Additional information:_____

Only If As A Parent You Object To A Physical or Immunization For Your Child.

Please initial

___ Religious Exemption - The parent or guardian shall submit a written statement, signed by a parent or guardian that stating that the individual is in good health and stating the general reason for such objections, as well as a written statement signed by a Physician that the individual is in good health.

___ Immunization Contraindicated - The parent or guardian shall submit a written statement, signed by a parent or guardian that stating that the individual is in good health and stating the general reason for such objections, as well as a written statement signed by a Physician that the individual is in good health and will not be required to provide a health history.

___ Exclusion – In situations when one or more cases of a vaccine- preventable or any other communicable disease are present in the program, all susceptible children, including those medical or religious exemptions, are subject to exclusion as described in the Reportable Diseases and Isolation and Quarantine Requirements.

Parent Authorization (must be signed by parent/guardian to authenticate)

The medical history herein is correct to the best of my knowledge and the person described herein has my permission to engage in all prescribed program activities except as noted. I hereby release the Sandwich Recreation Department and its Super Fun Program at Oakcrest Cove Staff from any responsibility or liability for any injuries or illnesses that may occur while my child is attending the Super Fun Program. I also release the prescribed medication administered to my child under the direction of my family doctor. In the event that I cannot be reached in an emergency, I hereby give permission to the emergency responders selected by the Recreation Director and/or program Director/Nurse to hospitalize and/or secure proper treatment for my child as named in this form. This form may be photocopied for use by emergency responders.

Parent's/Guardian's Signature: _____ Date:_____

IMPORTANT - A COPY OF THE PARTICIPANT'S **PHYSICIAN'S EXAM (WITHIN 18 MONTHS) MUST BE SUBMITTED TO THE RECREATION OFFICE NO LATER THAN JUNE 1st .**

A COPY OF A WRITTEN **MEDICAL CONSENT FORM** MUST ALSO BE COMPLETED & SIGNED BY A PHYSICIAN AND ACCOMPANY THIS FORM