

Participant Medical & Health Form

One form per participant must be filled out by a guardian and returned to the Parks and Recreation Department to be kept on file. This form is to assist us in making individual assessment of participant needs and reasonable accommodations.

Section 1: Participant Information

Participant Name:		Date of birth:	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Nickname:	School Attending:	Grade:	Approx. height:	Approx. weight:	
Address:		City:		State:	Zip Code:

Section 2: Guardian Information

Name:	Home Phone:	Work Phone:	Cell Phone:		
Relationship to Participant:		Email Address:			
Address:		City:	State:	Zip Code:	

Section 3: Emergency Contact Information (someone other than the guardian who may be contacted in case of an emergency)

Name:	Home Phone:	Work Phone:	Cell Phone:		
Address:		City:	State:	Zip Code:	

Section 4: Medical Information

Primary Care Physician:	Phone Number:	<small>If your child does not have health insurance, call 1-877-CT-HUSKY</small>	Dentist:	Phone Number:
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Section 5: Health History

Medication:	The Parks and Recreation Department staff is not medication administration certified; they will not administer medication to participants. Be advised that there is no nurse on duty during recreation activities.	1. Does the participant take any medication?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No			
		2. Does the participant carry an epinephrine pen?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No			
		3. Does the participant carry rescue inhaler?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No			
Immunization:	ALL participants must be up-to-date on immunizations.								
Allergies:	Does the participant have any allergies to food or medication?					<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Allergy:	Reaction:	Management/care:						
	Allergy:	Reaction:	Management/care:						
	Allergy:	Reaction:	Management/care:						

Section 6: General Wellness

Has or does the participant have any of the following:			
1. Any recent injury, illness or chronic disease?	<input type="checkbox"/>	Yes	No
2. Ever been dizzy/passed out during physical exercise?	<input type="checkbox"/>	Yes	No
3. Ever had seizures/diagnosed with seizure disorder?	<input type="checkbox"/>	Yes	No
4. Ever had surgery? If yes, please list below.	<input type="checkbox"/>	Yes	No
5. Have difficulty with vision, hearing, or speech?	<input type="checkbox"/>	Yes	No
6. Have any restrictions to activities?	<input type="checkbox"/>	Yes	No
Please use this space to explain any yes answers:			

Section 7: Additional Information

<i>Please provide any additional information about the participant's behavior and/or physical, emotional or mental health concerns that the Parks and Recreation Department should be aware of to accommodate the participant.</i>						
Would you like to have an individual accommodation conversation/meeting with the program coordinator?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
May we speak to school-day staff about your child?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Section 8: Signature

I attest the information above is correct and complete to the best of my knowledge. The participant herein may engage in all recreation program activities, except as noted. I give permission to the New Britain Parks and Recreation Department to seek emergency medical treatment when needed. I agree to the release of any information for the necessary treatment or referral purposes. If I cannot be reached in the event of an emergency, I hereby give permission to the New Britain Parks and Recreation Department to arrange necessary transportation for the participant and give permission to the physician on duty to secure and administer treatment, including hospitalization.

Guardian Signature: _____

Date: _____

OFFICE USE ONLY	Initial date received:	Staff initials:	Date updated:	Staff initials:
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