Springfield YMCA Medical and Parental Permission Form

ONE FORM PER CHILD – Please duplicate as needed

School forms MUST be returned BEFORE first day of School!

School:_____

Name of Participant _____Birthdate_____Sex_____

Address _____City _____Zip_____

Custodial Parent/Guardian

Name _____

Contact Numbers _____(H) _____(Cell)

Address _____City _____Zip_____

(If different from participant's address)

Employer _____Work Phone _____

Second Parent or Adult Contact

Name _____

Contact Numbers _____(H) _____(Cell)

Address _____City _____Zip_____

(If different from participant's address)

Employer _____Work Phone _____

Additional Emergency Contact

Name _____

Contact Phone Numbers (please provide two) _____ _____

Relationship to Participant_____

Address _____City _____Zip_____

Adults authorized for pick up other than those listed above

Adult Name	**Relationship To Child**	**Contact Number**	**Alternative Number**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If child needs medical treatment

Childs's Primary Physician _____

Address _____City_____Zip_____

Phone _____

Preferred Hospital: _____Insurance Carrier_____

Dentist/Orthodontist _____Eye Doctor_____

Primary Medical Information

Allergies:	**Type/Product**	**Reaction**	**Recommended Treatment**
Medication	_____	_____	_____
Food	_____	_____	_____
Other	_____	_____	_____

☐ Participant takes **NO** medications routinely ☐ Participant takes routine medications:

	Type	**Dosage**	**Time of Day**	**Comments**
Medication	_____	_____	_____	_____

Medical History

❑ I have attached a current list of immunizations and dates received as provided by my child's primary care physician.

Does child currently have, or ever been treated for any of the following?

		Yes	No			Yes	No
1.	Recent injury, illness or infectious disease	□	□	15.	Diagnosed heart murmur	□	□
2.	Chronic or recurring illness/condition	□	□	16.	Back injury or reoccurring back pain	□	□
3.	Illness or injury resulting in hospitalization	□	□	17.	Pain with joints (e.g., knees, ankles)	□	□
4.	Surgery (please provide date of last surgery)	□	□	18.	Orthodontic/Dental appliance	□	□
5.	Frequent headaches	□	□	19.	Skin problems (e.g., itching, rash, acne)	□	□
6.	Head injury (please provide date)	□	□	20.	Diabetes	□	□
7.	Fainting	□	□	21.	Asthma (does child have an inhaler)	□	□
8.	Glasses, contacts or protective eye wear	□	□	22.	Mononucleosis in past 12 months	□	□
9.	Frequent ear infections	□	□	23.	Diarrhea/constipation	□	□
10.	Passing out during or after exercise	□	□	24.	Abnormal menstrual history (female only)	□	□
11.	Dizziness during or after exercise	□	□	25.	Eating disorder	□	□
12.	Seizures (please provide date of last seizure)	□	□	26.	Emotional difficulties for which professional counseling has been sought	□	□
13.	Chest pains during or after exercise	□	□				
14.	High blood pressure	□	□				

If you answered YES to any of the questions above, please explain.

Number **Explanation**

_____ _____

_____ _____

_____ _____

_____ _____

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health:

_____

_____

_____

_____

Parent/Guardian Authorization:

This information is correct and complete as far as I know, and person herein described has permission to engage in all program activities except as noted in a separate written form. I hereby give permission to the program to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the program to arrange necessary related transportation for the participant. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program to secure and administer treatment, including hospitalization, for the person named above. This form may be photocopied as necessary for treatment or for program related travel.

Signature of parent/guardian_____

Print name _____ **Date** _____