

SIGNIFICANT HEALTH HISTORY

CURRENT CONDITIONS

Child's Name: _____

Please list:

Medication Taken:

Appliance Worn (Glasses, Etc.) _____

Conditions Which Modify Activities (Seizures, Amnesia, Heart Conditions, Etc.) _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp and Year-Round Afterschool and Youth Center Program staff to obtain necessary emergency medical treatment for my child with understand that the family will be notified as soon as possible.

Relationship _____

Signature _____

Date _____