CITY OF MARATHON PARKS AND RECREATION HEALTH INFORMATION

PLEASE PRINT
PARTICIPANT'S NAME: ____

BIRTH DATE: ________- ________ - ________ AGE: ________ SEX (Circle One) M F

Parent/Guardian's Name: ____

Home Phone: __________________ Work Phone: ______________________ Cell Phone__________________

PHYSICAL CONDITION: Please note any conditions, which affect your child and symptoms to help us identify possible problems. Also please list any past (or current) medical problems that your child has had (or has) that we should be aware of?

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ALLERGIES:

Food Allergies: ____

Symptoms: ____

Action to be taken by staff in event of onset____

Drug Allergies: ____

Symptoms: ____

Action to be taken by staff in event of onset: ____

Insect, Environmental or Other Allergies: ____

Symptoms: ____

Action to be taken by staff in event of onset: ____

Please answer the following (if yes and there are multiple choices please circle the appropriate one):

___ Yes ___ No Does your child have Asthma?

___ Yes ___ No Does your child have Diabetes?

___ Yes ___ No Is your child sun sensitive.

___ Yes ___ No Is your child ADD, ADHD or LD?

___ Yes ___ No Does your child have Seizures, Fits or Shaking Spells?

___ Yes ___ No Does your child have Speech, Hearing or Sight Limitation, tubes in ears?

___ Yes ___ No Does your child suffer from headaches or stomach aches?

___ Yes ___ No Does your child Attend a special needs class in school?

____ ____________________

Parent's/guardian's Signature **Date**