



CITY OF  
**MARATHON**, FLORIDA  
Parks & Recreation Department

200 36th Street, Marathon, FL 33050  
Phone (305) 743-6598 Fax (305) 289-5888

**Health Information Form 2019**

Please fill out clearly and return with registration. Bring to the park office, fax to (305)289-5888, or email.

Participant's Name \_\_\_\_\_

Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Sex  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?

**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 CHECK ALL THAT APPLY** (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 stomachaches?
- Yes  No Does your child attend a special needs class in school?
- Yes  No Does your child know how to swim?

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date