Sunday Funday
Health Form 2016-2017

This side to be completed by parent/ guardian. Please print/type. Return fully completed form (both sides) to:
YM&YWHA of Washington Heights & Inwood, 54 Nagle Avenue, New York, NY 10040

Child Name: _____ DOB: _____ Sex: _____ Age: _____

Parent/ Guardian: _____ Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Bus. #: _____ Cell #: _____ Email: _____

Parent/ Guardian: _____ Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Bus. #: _____ Cell #: _____ Email: _____

IF PARENT NOT AVAILABLE IN AN EMERGENCY, NOTIFY:

Name: _____ Relationship: _____ Bus#: _____

Cell#: _____ Address: _____

HEALTH HISTORY—(CHECK— GIVING APPROXIMATE DATES)

Has/ Does the Child:	YES	NO
1. Had any recent injury or infectious disease?		
2. Have a chronic or recurring illness/ condition?		
3. Ever been hospitalized?		
4. Ever had surgery?		
5. Have frequent headaches?		
6. Ever had a head injury?		
7. Ever been knocked out unconscious?		
8. Wear glasses, contacts, or protective eye wear?		
9. Ever had frequent ear infections?		
10. Ever passed out during or after exercise?		
11. Ever been dizzy during or after exercise?		
12. Ever had a seizure?		
13. Ever had chest pain during or after exercise?		
14. Ever had high blood pressure?		

	YES	NO
15. Ever been diagnosed with a heart murmur?		
16. Ever had back problems?		
17. Ever had problems with joints (e.g knees, ankles)?		
18. Have an orthodontic appliance?		
19. Have any skin problems (e.g itching, rash, acne)?		
20. Have diabetes?		
21. Have asthma?		
22. Had mononucleosis in the past 12 months?		
23. Had problems with diarrhea/ constipation?		
24. Have problems with sleepwalking?		
25. If Female, have abnormal menstrual history?		
26. Have history of bed-wetting?		
27. Ever had an eating disorder?		
28. Ever had emotional difficulty for which professional help was sought?		

HAS THE CHILD HAD ANY OF THE FOLLOWING? _____MUMPS _____ASTHMA _____INSECT STINGS _____CHICKEN POX _____ HEPATITIS A
_____HEPATITIS B _____HAY FEVER _____POISON IVY _____GERMAN MEASELS _____PEANUTS _____POISON IVY _____OTHER DRUGS

Please explain any "YES" answers: _____

_____

Any specific activities to be encouraged or limited by physician's advice _____

_____

Dietary modification: _____

Current medications (send with instructions): _____

I hereby give permission to the medical personnel selected by the Y Staff to provide routine health care; to administer medications; to order X-Rays, routine tests, treatment; to release any records necessary for insurance purposes: and to provide or arrange relation transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program director to secure and administer treatment including hospitalization, for the person named above.

Signed: _____ Date: _____

IMMUNIZATION SECTION (SEE OVER) ALSO MUST BE COMPLETED

Parent, guardian, or physician may complete this information.

GENERAL QUESTIONS (Explain "YES" answers below)

BP: _____ Weight: _____ Height: _____

TB Mantoux Test/ Date of Last Test: _____ Result: ☐ Positive ☐ Negative

PLEASE INDICATED DATE OF IMMUNIZATION:

IMMUNIZATION	MONTH/YEAR	MONTH/YEAR	MONTH/YEAR	MONTH/YEAR	MONTH/YEAR
DTP					
DT					
GERMAN MEASLES					
MONONUCLEOSIS					
MUMPS					
RUBELLA					
HAMOPHIUS INFLUENZA B					
HEPATITIS B					
VARICELLA (CHICKEN POX)					
POLIO					

Current Treatment/Medications, any Limitations: _____

_____

Allergies: ☐ No ☐ Yes (List): _____

_____

RECOMMENDATIONS/ RESTRICTIONS WHILE AT PROGRAM:

Does the child have a bronchial inhaler, bee sting kit, epi-pen, or other health related devices? _____

_____

Medication(s) to be administered (includes dosages and times of administration): _____

_____

To the best of my knowledge, there ☐ is ☐ is not a medical contraindication to be administering acetaminophen (Tylenol).

Child's Licensed Physician's Name (Please Print): _____ Phone: _____

Home Address: _____ City: _____ State:_____ Zip:_____

Date of completion of this form: ____/____/____

*Please Note: We do not administer any medications on site.

*Please Note: We encourage our staff to help participants apply sunscreen when necessary and appropriate.

I hereby attest that the information on both sides of this form is correct.

_____ _____

Parent/ Guardian/ Physician Signature **Date**