54 Nagle Avenue
New York, N.Y. 10040
Phone 212-569-6200 Fax 212-567-5915
www.ywashhts.org

Be Me Health Form

This side to be completed by parent/guardian. Please print/type. Return fully completed form (both sides) to above address.

Child Name:_____ Birthdate_____Gender_____ Age _____

Parent/Guardian_____Phone (_____)_____

Home Address _____City_____State_____ Zip_____

Cell# (___) _____ Email_____

Second Parent/Guardian _____Phone_____

Home Address_____City_____ State_____ Zip_____

Cell# (____) _____ Email_____

IF PARENT NOT AVAILABLE IN AN EMERGENCY, NOTIFY:

Name_____Relationship_____ Phone (____)_____

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 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?		
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?

_____ MEASLES
_____ CHICKEN POX
_____GERMAN MEASLES
_____ HEPATITIS A
_____ HEPATITIS B
_____ HEPATITIS C

ALLERGIES: _____MUMPS _____ ASTHMA _____ INSECT STINGS
_____OTHER _____HAY FEVER _____PENICILLIN _____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 related 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_____

_____

T B MANTOUX TEST/DATE OF LAST TEST _____

RESULT: ____POSITIVE ____ NEGATIVE

PLEASE INDICATE DATE OF IMMUNIZATI	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.
	_____	_____	_____	_____	_____
DTP	_____	_____	_____	_____	_____
DT	_____	_____	_____	_____	_____
German Measles	_____	_____	_____	_____	_____
Mononucleosis	_____	_____	_____	_____	_____
Mumps	_____	_____	_____	_____	_____
Rubella	_____	_____	_____	_____	_____
Hamophius influenza B	_____	_____	_____	_____	_____
HEPATITIS B	_____	_____	_____	_____	_____
Varicella (Chicken Pox)	_____	_____	_____	_____	_____
Polio					

_____

Current treatment/Medications: Any Limitations:

_____

Allergies: _____ None _____ Yes (List):_____

_____

_____

Recommendations/Restrictions while at program:

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

_____

Medication(s) to be administered (Includes dosages and times of administration);

_____

Any medically prescribed meal plan or dietary restrictions:_____

_____

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

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

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.
By signing the below, I acknowledge and okay the Y staff's ability to provide my children with this service.

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

_____ _____

Guardian/Parent/Physician Signature Date

M&YWHA
Washington Heights & Inwood

54 Nagle Avenue
New York, NY 10040
Phone 212-569-6200
Fax 212-567-5915
www.ywashhts.org

Be Me
After School Program at the Y

Be Me Parental Medical Authorization for Pediatric Emergency Medical and/Or Surgical Treatment and Allergies

Authorization: In case of emergency, I hereby authorize the doctor or the hospital to which my child or children may be brought, (and whomever they may designate as their assistants), to perform any emergency procedure or operation, to give treatment and the administration of anesthetic to my child during his/her stay in program.

Signed: _____(Relation to Child)_____

Signee Print Name: _____

Name of Child: _____ **Age:**_____ **Gender:** _____

Date of Birth: _____

Does family have medical insurance: ☐ YES ☐ NO

Name of Insurance Company: _____

Policy Number: _____

Social Security Number and Name of Primary Insured:_____

Explanation:

1. It is the firm hope that the authorization of this form will never need to be used. For the safety of children, however, sound medical practice calls for such authorization. In emergency situations, where for some reason the parent of the child cannot be contacted immediately, this form may be extremely important. The authorization granted by this form would be used only where absolutely necessary and only after every attempt has been made to first contact the parent/guardian or other emergency contact.
2. We find that the doctors and hospitals are reluctant to provide any treatment, no matter how minor, unless they have authorization from a parent. As you know, time can be a factor in being of assistance to your child where medical attention is needed, and this helps assure that no time is lost in giving medical attention.
3. This authorization form will be kept on file at the Y.