



Town of Sandwich  
 Recreation Department  
**Super Fun Summer Program**

**Medical Form**

**General Information**

Child's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

Participant's Summer Address: \_\_\_\_\_

Mother's/Guardian 1: Full Name: _____ Relationship to child: _____ Home Phone # _____ Work Phone # _____ Cell Phone # _____	Father's/Guardian 2: Full Name: _____ Relationship to child: _____ Home Phone # _____ Work Phone # _____ Cell Phone # _____
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In the event that a Parent or/and Guardian cannot be reached please list two additional contacts:

Emergency Contact #1 \_\_\_\_\_ Phone(H) \_\_\_\_\_ Phone(W) \_\_\_\_\_  
 Relationship \_\_\_\_\_

Emergency Contact #2 \_\_\_\_\_ Phone(H) \_\_\_\_\_ Phone(W) \_\_\_\_\_  
 Relationship \_\_\_\_\_

Do you carry family medical/hospital insurance?    NO    YES    if yes, please indicate:

Carrier: \_\_\_\_\_ Policy/Group# \_\_\_\_\_

If the parent/guardian or emergency contact cannot be reached, is permission granted to the Program Director/Nurse for emergency treatment to be given?    YES    NO

If necessary, is permission granted to the Program Director/Nurse for your child to be taken to the hospital?  
 YES                      NO

Child's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

**Physician Information**

Name of Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Dentist/Orthodontist: \_\_\_\_\_ Phone # \_\_\_\_\_

**Medication Information**

Is your child on any medication? NO YES

If yes, please complete the following:

Diagnosis	Physician	Medication	Dosage/Time
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How is medication given? \_\_\_\_\_

Additional information: \_\_\_\_\_

**Medical History**

In order to better serve your child, please indicate in detail any needs, disabilities, or concerns that your child has (include hearing aids, glasses, contacts, braces, wheelchair, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have difficulty in any of the following areas? (Please circle any/all that apply.)

Neurological      Orthopedic      Hearing      Vision      Motor Impairment

Additional information: \_\_\_\_\_

**Allergies**

Food (please list and describe reaction): \_\_\_\_\_

Medication(s): \_\_\_\_\_

Other (please list): \_\_\_\_\_

Child's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

**Behavioral**

Does your child have any behavioral difficulties? NO YES (Please circle any/all that apply.)

Hitting Pinching Kicking Tantrums Non-Compliant Biting Hyperactivity  
Screaming ADD ADHD Task Refusal Running Away Short attention span  
Self-stimulation Crying

Additional information: \_\_\_\_\_  
\_\_\_\_\_

Is your child currently on a behavior modification plan at school? NO YES

Name of your child's school: \_\_\_\_\_ Teacher's name: \_\_\_\_\_

Is your child currently on a behavior modification plan at home? NO YES

**Toileting**

Does your child need any assistance in toileting? NO YES

Additional information: \_\_\_\_\_

**Eating**

Does your child need any assistance in eating? NO YES

Additional information: \_\_\_\_\_

**Only If As A Parent You Object To A Physical or Immunization For Your Child.**

**Please initial**

\_\_\_ Religious Exemption - The parent or guardian shall submit a written statement, signed by a parent or guardian that stating that the individual is in good health and stating the general reason for such objections, as well as a written statement signed by a Physician that the individual is in good health.

\_\_\_ Immunization Contraindicated - The parent or guardian shall submit a written statement, signed by a parent or guardian that stating that the individual is in good health and stating the general reason for such objections, as well as a written statement signed by a Physician that the individual is in good health and will not be required to provide a health history.

\_\_\_ Exclusion – In situations when one or more cases of a vaccine- preventable or any other communicable disease are present in the program, all susceptible children, including those medical or religious exemptions, are subject to exclusion as described in the Reportable Diseases and Isolation and Quarantine Requirements.

**Parent Authorization (must be signed by parent/guardian to authenticate)**

The medical history herein is correct to the best of my knowledge and the person described herein has my permission to engage in all prescribed program activities except as noted. I hereby release the Sandwich Recreation Department and its Super Fun Program at Oakcrest Cove Staff from any responsibility or liability for any injuries or illnesses that may occur while my child is attending the Super Fun Program. I also release the prescribed medication administered to my child under the direction of my family doctor. In the event that I cannot be reached in an emergency, I hereby give permission to the emergency responders selected by the Recreation Director and/or program Director/Nurse to hospitalize and/or secure proper treatment for my child as named in this form. This form may be photocopied for use by emergency responders.

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

**\*\*IMPORTANT - A COPY OF THE PARTICIPANT'S PHYSICIAN'S EXAM (WITHIN 18 MONTHS) MUST BE SUBMITTED TO THE RECREATION OFFICE NO LATER THAN JUNE 1<sup>st</sup> .\*\***

**A COPY OF A WRITTEN MEDICAL CONSENT FORM MUST ALSO BE COMPLETED & SIGNED BY A PHYSICIAN AND ACCOMPANY THIS FORM**