TOWN OF COVENTRY DEPARTMENT OF PARKS & RECREATION
PROGRAM MEDICAL FORM
*Incomplete forms will not be accepted. One form per child.

Child's Name:_____ **Date of Birth:** _____ **Grade in Fall:** _____
Guardian's Name: _____ **Phone #:** _____
Emergency Contact: _____ **Phone #:** _____

Please answer the following health history questions about your child:

Any health concerns/medical conditions?	☐ YES	☐ NO
Any daily medication(s)?	☐ YES	☐ NO
Any allergies?	☐ YES	☐ NO
Special Diet/Dietary Restrictions?	☐ YES	☐ NO
Any history of Asthma, Seizures, other chronic diseases?	☐ YES	☐ NO
ADHD/ADD?	☐ YES	☐ NO

****If YES to any of the above statements, please complete the *Supplemental Information Form for Children with Medical Conditions or Support Services*****

☐ This child has a developmental, emotional, behavioral or psychiatric condition that may affect his or her program experience.

****If YES, please complete the *Supplemental Information Form for Children with Medical Conditions or Support Services*****

This child may:
☐ participate fully in the program
☐ not participate in the following activities:

_____

Is there anything you would like to discuss with Camp staff? ☐ YES ☐ NO
If YES, please explain:

_____

Preferred Hospital: _____

****If you answered yes to any of the above questions, additional documentation is REQUIRED.**
Please provide the appropriate supplemental forms, i.e. Supplemental Information Form, Authorization for the Administration of Medication/Epi-Pen, Health Care/Treatment Plan, etc.**

Release:
The information contained herein is accurate to the best of my knowledge. By my signature below, I consent to the following:

A. Release of any and all medical, insurance and/or other records to third party, which are in the possession of Town of Coventry or any other party referred to herein.
B. For Town of Coventry to acquire medical, insurance, and/or other data from third parties to be added to this record, and for those third parties to release such information to the Town of Coventry.
C. I authorize duly-licensed physicians, nurses and allied health professionals to provide such necessary medical care and to administer such routine diagnostic tests and procedures as in the judgment of the authorized personal is deemed necessary or advisable for the care of the individual person herein. If the information contained herein refers to an individual other than myself, I am their authorized legal representative and/or guardian and am hereby authorized to submit this material and execute this release form.

X_____ _____
Parent Signature Date