



DEPARTMENT OF RECREATION AND PARKS



Health Assessment

This Registration Form shall be completed by the legal authorized parent or guardian of minor/child participant. This information may be shared with staff and volunteers for the purpose of the administration of the program.

Child's Name: Last _____ First _____ Date of most recent physical exam _____

Where do you usually take your child for medical care? _____

Name of provider _____ Phone _____

Address of provider _____

Assessment of Child Health

To the best of your knowledge, does you child have a history of or any problems with the following: Please check "yes" or "no".

- Birth Defects Yes ___ No ___ Comment _____
- Prematurity Yes ___ No ___ Comment _____
- Hospitalization (when and where) Yes ___ No ___ Comment _____
- Concussion (head injury) Yes ___ No ___ Comment _____
- Surgery Yes ___ No ___ Comment _____
- Lead Poisoning Yes ___ No ___ Comment _____
- Eye or Vision Problems Yes ___ No ___ Comment _____
- Ear Problems or Deafness Yes ___ No ___ Comment _____
- Speech Problems Yes ___ No ___ Comment _____
- Cerebral Palsy Yes ___ No ___ Comment _____
- Meningitis Yes ___ No ___ Comment _____
- Heart Problems Yes ___ No ___ Comment _____
- Serious Allergic Reactions Yes ___ No ___ Comment _____
- Behavior or Emotional Problems Yes ___ No ___ Comment _____
- Allergies – Food, Insect, Drug, etc. Yes ___ No ___ Comment (symptoms) _____
- Asthma Yes ___ No ___ Comment _____
- Sickle Cell Disease Yes ___ No ___ Comment _____
- Diabetes Yes ___ No ___ Comment _____
- Seizures Yes ___ No ___ Comment _____
- Bleeding Problems Yes ___ No ___ Comment _____
- Limits on Activities Yes ___ No ___ Comment _____
- Problems with Bladder Yes ___ No ___ Comment _____
- Problem with Bowels Yes ___ No ___ Comment _____
- Are all immunizations current?** Yes ___ No ___ Comment _____
- Should there be a restriction of physical activity? Yes ___ No ___ Comment _____
- Are any medications being taken? Yes ___ No ___ Comment _____
- Special medical procedures that may be needed? Yes ___ No ___ Comment _____

Additional information or comments that may be helpful for staff _____

Signature of parent/guardian _____ Relationship to participant _____

Print name of signatory _____ Date _____