

Medical History

Record Of Immunization:

	DPT	Polio	MMR shot _____ (date)
2 months	_____	_____	- or -
4 months	_____	_____	Measles _____ (date)
6 months	_____	_____	Mumps _____ (date)
18 months (booster)	_____	_____	Rubella _____ (date)
5 year (booster)	_____	_____	

Date of last dental exam: _____ Date of last eye exam: _____

Does your child wear glasses or contact lenses? (glasses should be shatterproof) _____

Indicate which of the following diseases your child has had by writing his or her ages at the time:

Chicken pox: _____	German Measles: _____	Strep Throat: _____
Bronchitis: _____	Mumps: _____	Rheumatic Fever: _____
Pneumonia: _____	Ear Infection: _____	Whooping Cough: _____
Measles: _____	Hepatitis: _____	Mononucleosis: _____

Other Serious illness: _____

Injuries (fractures, concussions, etc.) _____

Has your child had an operation? _____ Please give dates: _____

Has your child ever manifested any forms of allergy? Yes: _____ No: _____

If yes to what: _____

Are there any know drug sensitivities? (penicillin, etc.) _____

Is your child currently taking any medication prescribed by a physician? Yes: _____ No: _____

If yes what? _____

Will this medication need to be administered during camp hours? Yes: _____ No: _____

Has your child ever had asthma? _____ If yes, please list effective medications and doses: _____

Does your child have any defects or abnormalities? _____

Parents signature: ✕ _____ **Date:** _____

All major emergencies will be transported by rescue squad to the Somerset Medical Center unless otherwise specified.

Other hospital desired: _____

Emergency treatment authorization:

I hereby give permission for the Hillsborough Pool, Racquet & Fitness Club to arrange and authorize emergency transportation to Somerset Medical Center where treatment is authorized if I, (please fill in name of parent or guardian), _____ am not available.

Signature: ✕ _____

I hereby authorize Hillsborough Pool, Racquet & Fitness Club management to transport my child to "Your Doctors Care" in the event of a minor orthopedic injury, laceration, or an allergic reaction.

Signature: ✕ _____

Name of family doctor: _____

Address: _____ Phone: _____