Health Form Reviewed by: (F&C Staff) _____ Date: _____

FREEDOM & CITIZENSHIP PROGRAM

HEALTH FORM

The information recorded here is required in case of an emergency. In order to provide services and to address special medical problems, we need accurate and complete information regarding your health. **All information is confidential.** Please **print** all information clearly.

Student's Name:	Parent's/Guardian's Name:
Address:	Address:
Cell Phone #:	Cell &/or Home Phone:
Home Telephone #:	Business Phone:
Date of Birth:	Relationship:
Emergency contact other than the parent/guardian of the student:	
Name:	Home Phone:
Address:	Business Phone:
	Relationship:
In the event of a student's illness or other medical emergency, Double Discovery Center will immediately see to his or her care. In order to seek medical attention we require the following information:	
Is the family covered by medical insurance? ◯ Yes ◯ No	Is the family covered by Medicaid? ◯ Yes ◯ No
Policy Name and number:	Medicaid number:
Company's name:	

ALLERGIES

Are you allergic to a substance, food or medication?	What type of reaction have you experienced?
Please indicate if you are currently being treated for allergies and what type of treatment you are receiving?	
Allergy:	Treatment/Medication:
Allergy:	Treatment/Medication:

MEDICAL HISTORY

Please read the list of conditions and illnesses that follow and check those you have now or have had in the past. Please give details of any conditions you now have or any serious consequences of past illnesses on a separate sheet.

☐ Measles	☐ Tuberculosis	☐ Diabetes	☐ Mumps	☐ Hepatitis; Type ____
☐ Kidney Disease	☐ Rubella (German sles)	☐ Heart Disease	☐ Arthritis	☐ DES Exposure

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☐ Chicken Pox	☐ Orthopedic Problems	☐ Asthma	☐ Dietary Problems	☐ Polio
☐ High Blood Pressure	☐ Abdominal Pap ear	☐ Gynecological Problems	☐ Rheumatic Fever	☐ Menstrual Problems
☐ Neurological Disorders	☐ Serious Gastro-Intestinal Problems			
☐ Other, please specify:				

Please answer the following question accurately and completely. Use additional sheets of paper if necessary.

Have you had surgery? If yes, what type and when?

Have you been hospitalized for any reason? For what and when?

PRESCRIPTION MEDICATION BEING TAKEN

List all prescription medication. Keep it in the original packaging bottle that identifies the prescribing physician, name of the medication, dosage, and frequency of administration.

This student takes **NO** medication on a routine basis ◯

This student takes medication as follows ◯

Med #1 _____ Dosage _____ Specific Times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific Times taken each day _____

Reason for taking _____

Attach additional pages for more medications or information about side effects.

OVER THE COUNTER MEDICATIONS BEING TAKEN

My child will be taking over-the-counter medications (such as headache relief medicine, cough drops, decongestants, etc)

◯ Yes ◯ No

List any over the counter medications that child will be taking during the summer:

_____

FAMILY HISTORY

Please tell us who in your family has or had any of the following health problems. Tell us the present state of health or the cause of their death on a separate sheet.

☐ High Blood Pressure	☐ Seizure Disorders	☐ Kidney Disease	☐ Cancer, Type: _____
☐ Tuberculosis	☐ Allergies	☐ Alcoholism	☐ Diabetes: _____
☐ Coronary Artery Disease (angina, heart attacks)		Other Significant Illness: _____	

CURRENT HEALTH STATUS

Please indicate in one or two sentences your present state of health.

What medication (over-the-counter or prescribed) have you taken for an extended period of time?
What medications do you take now?

Medication: _____	Extended Use From: _____	To: _____
Taking Now:		

RESTRICTIONS (Dietary)

☐ Does not eat red meat	☐ Does not eat fish	☐ Does not eat eggs
☐ Does not eat poultry	☐ Does not eat dairy products	☐ Halal

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☐ Kosher	☐ Other (describe)

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations necessary).

SIGNATURE

Throughout the year, students will go on a variety of trips both within the City of New York and to locations outside the City. By signing below, I give permission for my child (whose information is contained in this document) to participate in these trips and hereby authorize the Freedom & Citizenship Program and/or the Double Discovery Center to seek emergency medical attention for my child during his/her participation in the program.

Parent's Signature:		**Date:**	

Student T-Shirt Size (Options: Adult Small, Medium, Large, XL, XXL)