

**Health History Form for Children- 2011**

Schiff Summer Nature Programs for Kids  
339 Pleasant Valley Road Mendham, NJ 07945

**Child's Name** \_\_\_\_\_

**Confirmed Dates** \_\_\_\_\_  
\_\_\_\_\_

The information on this form is gathered to assist us in identifying appropriate care for your child should an emergency arise and is kept confidential by Schiff Natural Lands Trust personnel. Any changes to this form should be provided upon the participant's arrival. Please provide complete information so that we are aware of your child's needs.

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ M F  
*First Last Middle Initial*

Home address \_\_\_\_\_  
*Street City Zip*

**Custodial Parent/Guardian** \_\_\_\_\_ **Home address** \_\_\_\_\_  
*(If different from above) Street City Zip*

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ **Phone** \_\_\_\_\_  
*First Last Middle Initial*

Home address \_\_\_\_\_  
*Street City Zip*

Relationship to child \_\_\_\_\_

**Parent/Guardian Authorizations:** This health history is correct and complete as far as I know, and the person herein described has permission to engage in all program activities except as noted \*. I hereby give my permission to the Schiff Summer Programs for Kids instructors to provide routine first aid and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the instructors to arrange necessary transportation for my child in the case of an emergency. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the instructors to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

Printed name \_\_\_\_\_

\*Note: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES**

*(List and describe item, reaction, and management of the reaction)*

Food allergies \_\_\_\_\_  
\_\_\_\_\_

Other allergies—include insect stings, hay fever, asthma, animal dander, etc. \_\_\_\_\_  
\_\_\_\_\_

OVER →

**MEDICATIONS**

Please list ALL medications taken routinely. Attach additional pages if necessary. SCHIFF NATURAL LANDS TRUST PERSONNEL WILL NOT BE RESPONSIBLE FOR ADMINISTERING ANY MEDICATIONS.

My child **takes NO medications** on a routine basis.      **OR**       My child **takes medications** as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_

Reason for taking \_\_\_\_\_

**GENERAL QUESTIONS** (Explain any “yes” answers)

Has/does the participant:	<u>Yes</u>	<u>No</u>	<u>Explanation</u>
1. Had a recent injury, illness, or infectious disease?	___	___	_____
2. Have chronic or recurring illness/condition?	___	___	_____
3. Have frequent headaches?	___	___	_____
4. Ever had a head injury or been knocked unconscious?	___	___	_____
5. Wear glasses, contacts, or protective eyewear?	___	___	_____
6. Ever been dizzy or passed out during/after exercise?	___	___	_____
7. Ever had seizures?	___	___	_____
8. Ever had chest pain during/after exercise?	___	___	_____
9. Ever had problems with joints (e.g. knees, ankles)?	___	___	_____
10. Have any skin problems (eczema, rash, acne)?	___	___	_____
11. Have an orthodontic appliance?	___	___	_____
12. Have diabetes?	___	___	_____
13. Have asthma?	___	___	_____

Use this space to provide any additional information about the participant’s behavior and physical, emotional, or mental health about which the Schiff Natural Lands Trust personnel should be aware. \_\_\_\_\_

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

**CONSENT STATEMENT**

I understand that Schiff Natural Lands Trust reserves the right to dismiss my child from the program if his/her conduct is dangerous, destructive, or is not in the best interest of the program as a whole.

I give my permission for Schiff Natural Lands Trust to use any picture in which my child appears:

in print       on its website       decline

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_