Red Wing Family YMCA- School Year
Health Form (Physician's Section)

THE FOLLOWING INFORMATION MUST BE COMPLETED BY A LICENSED PHYSICIAN.
MAY BE FAXED BACK TO THE YMCA @ 388-5340

Note to the Physician

The participant named below will be attending YMCA School Year program. Because of the nature of this atmosphere, the participant will undergo much physical activity. The intent of the completed information in this Health Form is to provide our staff the background to administer appropriate care to the participant named below while he or she is attending.

Personal Information

Name of Participant:_____Birth Date:_____Age:_____

Gender (Male/Female):_____

Height:_____Weight:_____Blood Pressure:_____

Physician's Information

Printed Name of Physician:_____Phone: _____

Clinic/Health Care Facility: _____

Address: _____

Date of most recent examination: _____

Physician's Recommendation

Is the above named participant able to participate in an active program? _____Yes _____No

Explain any restrictions to activities (e.g. what cannot be done, what adaptations are necessary), and any treatments or medications that need.

_____
_____
_____
_____

Authorization

As a licensed physician, I verify that the participant named above has been examined and that the completed information in this Health Form has been reviewed. This completed form may be photocopied for trips off of the property.

_____
Signature of Licensed Physician Date

List any medications, you will want administered during the time your child is in our care. Keep it in the original container that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

Medication

The administration of medications will be followed according to what is prescribed on the medication bottle; if there are any changes to this, a signed physician's note stating these changes must accompany the medication.

_____The participant takes no medications on a routine basis.

_____The participant takes medications routinely as follows: (If more space is needed, list the information below on a separate sheet.)

Medication	Dosage	Specific time(s) of day	Reason for taking

Attach another page for additional medication.

Immunizations

Provide immunization dates (Mo/Yr) for the following vaccines:

Hepatitis B	_____	_____	_____	_____	_____
Haemophilus infl. B (Hib)	_____	_____	_____	_____	_____
DTP	_____	_____	_____	_____	_____
TD	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____
Other:_____	_____	_____	_____	_____	_____

Physical Restrictions

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

_____

_____

_____

Authorization- Signature of Parent / Guardian BELOW

IMPORTANT: THE FOLLOWING MUST BE COMPLETE TO ATTEND THE SCHOOL YEAR – SCHOOL AGE PROGRAM!

This health history is correct and complete to the best of my knowledge. I hereby give permission to the Child Develop Center director & staff to provide routine health care for the participant. In case of a life or death emergency, I hereby give permission to the physician/facility selected by the YMCA staff personnel to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for the participant in the event that the participant cannot make the decision on his or her own. The employed YMCA personnel shall be relieved of any responsibility. This completed form may be photocopied for trips off of the property.

_____

Signature of Parent/Guardian, Date