



Beaver Brook Association
117 Ridge Road
Hollis, New Hampshire 03049
603-465-7787, Fax 603-465-9546

Child's Program _____

**Exam date must be within two years
of class date**

Children's Summer Program Health Form

Health forms are required for all children attending BBA summer programs. This completed form must be returned to the BBA office **by June 1, 2007**. Completed health forms from other organizations will be accepted, as long as they contain the requested information and **the exam is within two years of class date**. All information will be kept **confidential**. BBA does not retain forms from previous years.

Child's Name: _____ Sex: Male Female

Date of Birth: _____ Home Phone # _____

Address: _____ City _____ State: _____ Zip: _____

Parent/Guardian Names: 1) _____ 2) _____

Best Phone # for emergency contact: 1) _____ 2) _____

Email Address: _____

In case of emergency, please contact (provide 2 names other than child's parents):

1) _____
name phone number relationship

2) _____
name phone number relationship

Personal Physician: _____ **Phone:** _____

Address: _____

Health Insurance Company: _____ Policy Number: _____

If Yes to any of the following questions, please call Beaver Brook Association two weeks before class begins:

Dietary Restrictions: (explain) _____

Activity Restrictions: (explain) _____

Allergic Reaction to Medications, Bee Stings, or Foods: (explain) _____

Does your child carry an allergy kit? No Yes (explain) _____

Other Allergies: (explain) _____

Asthma: Does your child carry an inhaler? No Yes (explain) _____

Other Medical Conditions (including diabetes, seizures, recent surgery or major illness): (explain) _____

ADD/ADHD Has learning differences

Utilizes an aide in the school classroom Has mobility impairment

Has emotional, social, physical special needs

Is your child presently taking any medications? If yes, please list below.

Name _____ Name _____

Dosage _____ Dosage _____

Reason for taking _____ Reason for taking _____

Will your child be taking any medications while participating in our programs?

Is your child capable of self-medicating? No Yes (The instructor will hold medication.)

Briefly describe how any of the checked items (from the previous page) may affect your child's experience in the summer programs:

Parent Authorization Statement

"In the event that I am unable to be reached in an emergency, I hereby authorize the Beaver Brook Association staff and/or medical personnel selected by Beaver Brook Association to take emergency measures as needed. I understand this may include related transportation, x-rays, routine tests, treatment, and release of records necessary for insurance purposes. The selected physician has my permission to secure and administer treatment, including hospitalization, for my child. This completed form may be photocopied for trips off the property."

Signature of Parent or Guardian

Date

Immunizations and Infectious Disease History
(To Be Completed by Physician)

Vaccine	Date of Basic Immunization	Year of Last Booster	Date of Illness
DPT (Diphtheria, Whooping Cough, Tetanus)			
Td (Tetanus, Diphtheria)			
Tetanus			
Polio (oral/Salk)			
Measles			
Mumps			
Rubella			
Hepatitis B (optional)			
Chicken Pox (optional)			
TB Mantoux Test Positive ___ Negative ___			

PHYSICIAN'S STATEMENT

"I have examined the above child within the two past years. In my opinion, the child's condition does not preclude his or her participation in an active camp program."

Physician's Signature

Date of form completion

Date of child's last exam: _____