Child Health Form

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Child Health Form

The information on this form is not part of the program acceptance process, but is gathered to assist us in identifying appropriate care should the need arise. Any changes to this information provided on this form must be provided to program personnel immediately. Provide complete information so that staff will be aware of your child's needs. We will make every effort to reach responsible parties, should the need arise, in the order listed below.

Participant's Name ____ Birth Date _________________

Home Address____

School____ Grade________________Gender_________________

Custodial parent/legal guardian ____

Home Address____Phone: ______________________
(If different from above)

Additional Phone(s): ____
Second parent or legal guardian or emergency contact____

Address____Phone:______________________

Additional emergency contact____
Relationship ____
Address ____Phone: ______________________

Insurance Information

Is the participant covered by family medical insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name _______________________________________ Group # _____________

Name of insured _______________________________________ Relationship to participant _____________

Allergies List all known. Describe reaction and management of the reaction

Medication allergies (list)

__________________ ____

__________________ ____

Food allergies (list)

__________________ ____

__________________ ____

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

__________________ ____

__________________ ____

Medications being taken

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Any medications that must be taken during program time should remain in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person **takes NO medications** on a routine basis OR

☐ This person **takes medications** during program times 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.

RESTRICTIONS (The following restrictions apply to this individual.)

Does not eat: ☐ Red meat
- ☐ Pork
- ☐ Dairy Products
- ☐ Poultry
- ☐ Seafood
- ☐ Eggs
- ☐ Food Dye
- ☐ Peanut Butter
- ☐ Gluten
- ☐ Sugar (those sugars not found in natural settings like fruits)
- ☐ Other _______________

Explain any restrictions to activity (e.g. activities in which the child cannot participate).

Use this space to provide additional information about the participant's behavior and physical, emotional, or mental health about which our programs' staff should be aware.

Name of family physician ____

Address ____

Phone ____

In all emergencies when prior authorization cannot be obtained from me or the other emergency contacts specified above, I authorize Berea College's CELTS program staff to secure emergency medical treatment on my child's behalf, including surgery and the administration of an anesthetic. I accept all financial responsibility for such treatment and expenses. I agree to release, indemnify and hold harmless Berea College, its trustees, officers, employees, students and agents, including staff of CELTS, in connection with any treatment rendered pursuant to the permission given in this document.

This form may be photocopied for trips off Berea College premises.

Information on this form may be shared with Berea College staff and students involved with CELTS programs.

Signed ________________________________ Date ____________________
(Parent or Legal Guardian Signature)

Printed Name ____