CYO PERSONAL HEALTH AND MEDICAL RECORD

DATE____________________

Name of Child	Sex	Date of Birth	Age:

Mother/Guardian's Name		Place of Employment
Address		Address
Telephone: Home	Cell:	Work:
Father's Name		Place of Employment
Address		Address
Telephone: Home	Cell:	Work:

In case we are unable to reach you, please give us an EMERGENCY contact:

Friend or Relative Name		Place of Employment
Address		Address
Telephone: Home	Cell:	Work:

If the Answer is YES to any of the questions below, please provide an explanation.

1. Does your child have any current health problems? ____________________
2. Is your child currently under medical care or taking any prescription medications? ____________________
3. Has your child had any surgery, illness, since your last complete exam? ____________________
4. Does your child have any allergies? ____________________
5. Has the allergy been diagnosed by a physician? ☐ Yes ☐ No

If yes, we must have a copy of the child's care plan completed your physician before your child starts our program

My child has or is subject to: (check all that applies)

☐ Asthma ☐ Contact Lenses ☐ Fainting Spells ☐ Diabetes

☐ Lactose Intolerance ☐ Convulsions/Seizures ☐ Heart trouble ☐ ADD/ADHD

☐ High Blood Pressure ☐ Any other condition that may require emergency or special care: (please describe)

Please describe: ____________________

Note: To substitute regular milk for soy or lactaid milk, a doctor's note is required.

BEFORE YOUR CHILD MAY ATTEND A CYO PROGRAM, A RECORD OF YOUR CHILD'S IMMUNIZATIONS MUST BE KEPT ON FILE AT THE CENTER ALONG WITH THIS FORM.
PRESCHOOLERS ARE REQUIRED TO PROVIDE <u>YEARLY</u> CURRENT PHYSICALS AND RECORDS OF IMMUNIZATIONS.

Please tell us of any health/behavior concerns or accommodation needs:

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We understand that this information is confidential and will only be shared with pertinent staff.

Pediatrician/Physician Name: ______________________ Phone # ______________

Address ____

AUTHORIZATION

To the best of my knowledge, this medical history is correct and complete. I know of no reason to restrict or limit my child's activity and give my permission for participation in all activities that are provided. In the event that I cannot be reached in an emergency, I hereby give permission to any physician selected by the CYO of Mercer County to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child named above.

I agree to let CYO staff treat my child's small cuts and bruises as needed. I understand that antiseptic wash, antibiotic creams such as, (but not limited to) bacitracin or neomycin may be used. A record will be made of any such incidents.

I recognize and acknowledge that there are certain risks of physical injury in any recreational program and I hereby assume full responsibility for any expenses incurred as a result of my child's participation in the CYO Program.

I agree to: (a) waive and relinquish; (b) fully release and discharge; and (c) indemnify and hold harmless the Mercer County CYO and the Diocese of Trenton and their officers, agents, and employees from any and all claims from injuries, damage or loss which may accrue to me on account of my child's participation in the CYO Program.

Parent/Guardian Signature______________________________ Date ______________