

**Health History Form for Children 2018**

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

Schiff Summer Nature Programs for Kids

Program Date(s) \_\_\_\_\_

339 Pleasant Valley Road Mendham, NJ 07945

The information on this form is gathered and kept confidential by Schiff Natural Lands Trust personnel. Complete information is required so that we identifying appropriate care for your child should an emergency arise.

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 \_\_\_\_\_ Email \_\_\_\_\_

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

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

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

Authorized Alternate Pickup(s) \_\_\_\_\_ Phone \_\_\_\_\_

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

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

Other/all allergies \_\_\_\_\_

**MEDICATIONS** (Please list ALL medications taken routinely. Attach additional pages if necessary)

**SCHIFF NATURAL LANDS TRUST STAFF WILL NOT BE RESPONSIBLE FOR ADMINISTERING ANY MEDICATIONS.**

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

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

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

Med ication \_\_\_\_\_ Dosage \_\_\_\_\_

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

**GENERAL QUESTIONS** (Explain any "yes" answers)

Has/does the participant:	Yes	No	Explanation
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. \_\_\_\_\_

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**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 \_\_\_\_\_