Health History Form for Children **2021** **Child's Name**_____

Schiff Summer Nature Programs for Kids Program Date(s) _____

339 Pleasant Valley Road Mendham, NJ 07945 _____

Parents DO NOT have to take this form to your doctor. Please complete yourself so that we can identify and respond with appropriate care should an emergency arise. The information on this form is gathered and kept confidential by Schiff Natural Lands Trust staff.

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/Bee 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 _____ Indicate if child will carry medication: Y_____ N_____

Medication_____ Dosage _____

Reason for taking _____ Indicate if child will carry medication: Y_____ N_____

SCHIFF NATURAL LANDS TRUST STAFF WILL NOT BE RESPONSIBLE FOR PROVIDING MODIFACATIONS AND SUPPLEMENTARY AIDS AND SERVICES FOR CHILDREN WHO HAVE DOCUMENTED NEED FOR SUCH IN THEIR LEARNING ENVIRONMENT. *Parents are responsible to provide accommodations in the same manner as their learning environment.*

MODIFICATIONS AND SUPPLEMENTARY AIDS AND SERVICES IN THE CLASSROOM *(Please describe any/all modifications documented in your child's IEP in their learning environment. Attach additional pages if necessary.)*

_____My child **requires NO accommodations** in their learning environment. **OR** _____My child **requires accommodations only in particular situations.**

Description of modification_____

Reason for modification_____

Situations requiring modifications for my child_____ _____

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?	___	__	_____

COVID-19 QUESTIONS (Explain any "yes" answers)

Has/does the participant:	Yes	No	Explanation
14. Been diagnosed with Coronavirus (COVID-19)?	___	__	_____
15. If diagnosed, was your son/daughter symptomatic?	___	__	_____
16. If diagnosed, was your son/daughter hospitalized?	___	__	_____
17. Have other household members been diagnosed with Coronavirus (COVID-19)?	___	__	_____

Please 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 Nature 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. If 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 _____