PLEASE PRINT CLEARLY WITH A BLACK OR BLUE PEN

Medical Information

Participant's Name: _____

Address: _____ Zip: _____

Home Phone: _____ Email Address: _____

Is participant a Waltham Resident: Circle: Yes No D.O.B.: _____

Age: _____ Entering Grade: _____ Circle: Male Female School: _____

ALLERGIES - MEDICATIONS - SPECIAL ACCOMMODATIONS

	Please Circle	
Does participant have any allergies (medications, environmental and/or food)?	Yes	No
Does participant currently take any medication and/or will take during a program?	Yes	No
Does participant need extra help or attention in any area?	Yes	No
Are there behavior or special needs that may need to be addressed?	Yes	No

If you answered yes to any of these questions, complete the section below.

Allergies - medications, environmental and/or food: _____

Medications taken at home: _____

Medications that will be taken/needed at the program (list dosage and times): _____

Please note: If your child will be taking any medication during a program, an "Authorization to Administer Medication" form must be completed. The form must be updated each season.

Please list any special arrangements or accommodations needed for your child, while attending the program:

_____

_____

_____

_____

_____

_____

_____

Parent/Guardian's Signature **Date**