NATIONAL MUSEUM OF MATHEMATICS

Transformations Summer Program: Health Record

Please note that MoMath does not have a nurse or other medical professional on the premises.

_____ _____ _____/_____/_____ ○Female ○Male

CHILD'S LAST NAME CHILD'S FIRST NAME DATE OF BIRTH

HOME ADDRESS:_____ TEL. NO._____

PARENT(S) OR GUARDIAN(S):_____ TEL. NO._____

FATHER/GUARDIAN'S EMPLOYER: _____ TEL. NO._____

MOTHER/GUARDIAN'S EMPLOYER: _____ TEL. NO._____

IN CASE OF EMERGENCY AND PARENT OR GUARDIAN IS NOT AVAILABLE, NOTIFY:

1. FAMILY PHYSICIAN: _____ TEL. NO._____

2. NAME/RELATIONSHIP:_____ TEL. NO._____

IMPORTANT: Was/Is your child exposed to any communicable diseases during the three weeks prior to *Transformations*?

○NO ○YES If YES, state type of exposure: _____

HEALTH HISTORY (Check and give approximate dates):

	Allergies	Diseases
Ear Infections _____	Hay Fever _____	Check Pox _____
Rheumatic Fever _____	Ivy Poisoning, etc. _____	Measles _____
Convulsion _____	Insect Stings _____	German Measles _____
Diabetes _____	Penicillin _____	Mumps _____
Behavior _____	Other Drugs _____	Other Contagious Illnesses _____
Asthmas _____	_____	_____

Other Past Illnesses: _____

Operations or Serious Injuries (Dates): _____

Hospitalization (Dates): _____

Chronic or Recurring Illness: _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

Permission for all program activities unless otherwise noted by doctor: _____

Appliance worn (glasses, contacts, etc.): _____

Medication taken: _____

Suggestion from Parent/Guardian: _____

By signing this form, you give permission for your child to participate in all program activities unless otherwise noted by a physician.

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the National Museum of Mathematics to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

_____ _____ _____ _____

Printed Name Signature Relationship Date