



HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)

First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address	City	Zip Code	Home Phone # ()

Mother/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ()

First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code	Home Phone # ()

Father/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ()

Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)

Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number ()

Name of Hospital Preference in case of emergency.

Yes	No	N/A	Complete the following information about medications for this child or youth.
			Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
			If yes above, is there signed permission on file?

Circle any of the following conditions or difficulties that affect this child or youth.			
Allergies	Frequent sore throats/ colds	Ear Infections or Aches	Heart or Lung Conditions
Skin Problems	Asthma	Headaches	Diabetes
Vision	Speech/Communication	Hearing	Emotion/Behavior
Other: Please describe.			

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.)

Complete the following information about this child's or youth's immunization status.

Yes	No	
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Infl. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed
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If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?
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I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	Date Signed
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AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license. City of Mission - Sylvester Powell Jr. Community Center	License # 0069459
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I hereby authorize Mission Parks & Recreation Dept. Camp Director/Asst Director (Name of individual/staff member) and/or Mission Parks & Recreation Dept. Full-time Staff (Name of individual/staff member) who is (are) representative(s) of the above named facility to give consent for any and all necessary emergency medical care for my child or youth _____ (First and Last Name of Child or Youth) while said child or youth is in said facility's custody between the dates of 06/06/2016 and Until Terminated.
MM/DD/YYYY MM/DD/YYYY

Signature of Parent or Guardian	Date Signed
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Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	Date Signed
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Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

State of <u>Kansas</u> County of _____
Signed or attested before me on _____ by _____ MM/DD/YYYY Name of Person
(Seal, if any.)
_____ Signature of notarial officer
_____ Title (and Rank)
My appointment expires: _____

List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:

Is child covered by health insurance? Yes No

If yes, complete the following:

Health Insurance Policy Name _____ Policy Number _____
Medical Assistance Program _____ Card Number _____
Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____

THE MEDICAL RECORD/ASSESSMENT FORM (OR HEALTH STATUS HISTORY FORM FOR SCHOOL AGE PROGRAMS) AND THE AUTHORIZATION FOR EMERGENCY MEDICAL CARE MUST BE TAKEN TO THE EMERGENCY ROOM. BOTH FORMS MUST ALSO BE IN A VEHICLE WHEN THE CHILD OR YOUTH IS TRANSPORTED BY THE FACILITY.

2016 ADDENDUM FORM

Mission Summer Camp & Tween 'N Teen Camp

Aquatics:

I understand MSC/TNT involves swimming at various pools.

Does Participant know how to swim?

Yes _____ No _____

If so, approx. what level? _____

Field Trips:

I give permission for my child to participate in all Fieldtrips and to be transported as authorized by Mission Parks & Recreation Department.

Yes _____ No _____ Initials _____

Sunscreen Permission:

The Kansas Department of Health and Environment prohibits camp staff from applying sunscreen to children without a parents or doctors' approval. Therefore, without your permission, camp instructors will not apply sunscreen to your child. Please apply waterproof sunscreen to your child before camp, each day. If you have a preferred sunscreen, please send it with your child, as the staff will remind children to re-apply sunscreen to themselves throughout the day.

I authorize the MSC/TNT Camp Staff to apply sunscreen to my child and supply extra sunscreen as needed.

Yes _____ No _____ Initials _____

Media Release:

I hereby grant the Mission Parks & Recreation Department permission to record my child/ward's or their likeness and/or voice for use in television, films, radio, or printed media to further the aims of the Parks and Recreation Program in related campaigns and magazine articles, booklets, posters and in other ways they may see fit.

Yes _____ No _____ Initials _____

Release of Liability:

I, the undersigned, as a participant or parent/guardian of the participant in the above named program and any swimming or tennis lessons offered in conjunction with this program, I do understand that, in consideration of the Parks & Recreation Department, City of Mission, KS, do release them, their officers, agents or employees from all liability demands or claim for loss, or damage of injury resulting from participating in the above, as there is no insurance provided. I recognize and understand that the above program requires that the participant be in good health, and I warrant and declare that the participant is in good health. If the participant is a minor, I also give my consent for his/her participation in the above program, and for any necessary emergency medical treatment. I hereby give authority to any hospital or doctor to render immediate emergency aid/or any medical surgical or hospital care, treatment and procedures as might be required at the time for my child's health and safety. I also give permission for my child to be transported by ambulance or aid car to and emergency center for treatment. I understand that any expense for this service is my responsibility.

Name of Parent or Guardian Registering Camper

Date

Signature of Parent or Guardian Registering Camper

Date

Please return ALL forms to Sarah Sooter to complete registration.

Mail: 6200 Martway, Mission, KS 66202 | **Fax:** 913.722.8218 | **Email:** ssooter@missionks.org

January 4,2016

Diving Permission Form:

I give my child, _____, permission to use the diving boards during Mission Summer Camp or the Tween 'N Teen Summer Camp, so long as he/she has passed the required swimming test administered by the certified testing lifeguards employed by the City of Mission, Parks & Recreation Department.

Yes

No

Parents name **PRINTED**

Parents name **SIGNED**

Date