Children's Museum of the Art
103 Charlton New York, NY 10014

Museum Programs Manager, Christina Fusco
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2019-2020 RELEASE AND CONSENT FORM/HEALTH RECORD

PAGE 1 TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN

_____ _____ ____/____/____ _____
Child's Last Name **First Name** **Birth Date** **Sex**

Class/Camp(s) Enrolled:_____

Home Address:_____ **Email**:_____

Parent/Guardian 1:_____ Cell #:_____ Second #:_____

Parent/Guardian 2:_____ Cell #:_____ Second #:_____

Emergency Contact:_____ Phone #:_____

Physician's Name:_____ Phone #:_____

IMPORTANT: **Please notify the Program Manager if this child has been exposed to any communicable diseases three weeks prior to today's date.** Exposure type: _____

HEALTH HISTORY (Check, giving approximate dates)

Has/Had:	____ Ear Infections	____ Asthma	____ Convulsion	____ Diabetes	____ Behavior
Allergies:	____ Food	____ Hay Fever	____ Insect Stings	____ Penicillin	____ Other
Diseases:	____ Chicken Pox	____ Measles	____ German Measles	____ Mumps	____ Other

Please describe: _____
Any recent Illnesses or Injuries _____ Operations (dates) _____
Contagious Illnesses_____ Hospitalization (dates) _____
Is child prone to head lice?_____ Chronic or Recurring Illnesses _____
Other conditions or Special needs: _____
Any specific activities restricted? _____

CURRENT CONDITIONS
Medication(s) Taken: _____
Appliances Worn (glasses, etc.):_____
Conditions which modify activity (seizures, amnesia, heart conditions etc.) _____
Does family have Medical Insurance? _____ Insurance Company: _____
Does family have Hospitalization Policy? _____ Policy # in case of emergency: _____

PHOTO/TRIP RELEASE & CONSENT FOR EMERGENCY MEDICAL TREATMENT & MEDICATION

- I give permission for my child's picture to be used by Children's Museum of the Arts in promotional materials without compensation (e.g. calendar, brochure, video, website, etc.).
- I hereby give permission for my child to participate in all program activities and day trips as part of the Children's Museum of the Arts Art Colony program unless noted otherwise on this form.
- I hereby give authority to Children's Museum of the Arts staff to administer over-the-counter medication in the proper dosage to my child if needed (e.g.: Tylenol, Motrin, Benadryl, etc.) and to administer other medication as prescribed by a physician without my further consent. In case of emergency, I give authority to Children's Museum of the Arts staff to obtain emergency treatment for my child with the understanding that the family will be notified as soon as possible, and I hereby authorize the doctor or the hospital to which my child may be brought (and whomever they may designate as their assistants) to perform any emergency procedure or operation, to give treatment, and to administer an anesthetic to my child during his/her stay at Children's Museum of the Arts Art Colony camp.

By my signature, I hereby certify that all above information is approved and correct unless otherwise indicated.

Parent/Guardian Name: _____ **Relationship to child**:_____

Signature: _____ **Date:** _____

GENERAL HEALTH RECORDS

The purpose of this health record is to provide our staff with pertinent information that will help to serve the needs of this child in case of an emergency while at The Children's Museum of the Arts. **To be filled out by child's physician OR attaching a copy of a recent physical examination is also acceptable.**

CHILD'S NAME (Last, First)_____

IMMUNIZATION HISTORY: This is a record of dates of basic immunization and most recent booster doses. According to New York State Law, a second MMR immunization must be administered to every child born before 1985.

DPT or DT or TD	Date_____	Date_____	Date_____	Date_____	Date_____
Polio	Date_____	Date_____	Date_____	Date_____	Date_____
Measles	Date_____				
Rubella	Date_____				
Mumps	Date_____				
MMR 2	Date_____	Tuberculin Test Given_____(most recent)			
Haemophilus Influenza Type B	Date_____				
Hepatitis B	Date_____				
Varicella (Chicken Pox)	Date_____				

MEDICAL EXAMINATION: To Be Filled Out by Licensed Physician
CODE: S=Satisfactory X = Not Satisfactory (explain) O = Not Examined
General Appearance:_____

Height _____	Eyes _____	Feet _____
Weight _____	Vision _____	Lungs _____
Blood Pressure _____	Glasses_____	Skin_____
Hgb. Test _____	Extremities _____	Nose _____
Urinalysis _____	Heart _____	Teeth _____
Posture & Spine _____	Ears _____	Hernia _____

Food Allergy: (Please Specify) _____
Recommended Treatment/Action Plan: _____
Other Allergy: (Please Specify) _____
Neurological Findings: _____
Describe Abnormal Findings and/or Handicapping Conditions:
_____
Has child ever received products containing horse serum?: _____

RECOMMENDATIONS AND RESTRICTIONS WHILE IN THE PROGRAM:
Special Diet: _____
Special Medication: _____
Will special medication need to be administered to child at camp? _____
If yes, directions for use: _____
Swimming _____ Diving _____ Strenuous Activity _____
General Appraisal/Comments: _____

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Children's Museum of the Arts Art Colony camp activities, except as noted above.

_____ M.D. Date of Examination: _____
Examining Physician

Address: _____ Phone: _____

_____
City, State Zip Code