2021 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 Associate Director if this child has been exposed to any communicable diseases two weeks prior to today's date, including COVID 19. 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. 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 Summer Studio 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 Summer Studio Program.

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 Children's Museum of the Arts. To be filled out by the child's physician OR attaching a copy of a recent physical examination.

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 the 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 the child during the program? _____
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 Summer Studio Program activities, except as noted above.

_____ M.D. Date of Examination: _____
Examining Physician
Address: _____ Phone: _____
City, State Zip Code: _____