MECHANICVILLE AREA COMMUNITY SERVICES CENTER, INC.

CHILD'S MEDICAL FORM (1 medical form per. Child)

Child's Name: _____

Health History: For all questions checked please give date of diagnosis and current management below, if appropriate.

	ALLERGIES	DISEASES
☐ Vision Impairment ☐ Hearing Impairment ☐ Frequent Ear Infections ☐ Heart Defect/Disease ☐ Diabetes ☐ Convulsions/Seizures ☐ Asthma ☐ High Blood Pressure ☐ Lung Disease ☐ Bleeding/Clotting Disorder ☐ Kidney Disease ☐ Cancer	☐ Hay Fever ☐ Ivy Poisoning, Etc. ☐ Penicillin ☐ Insect Stings Further Detail: _____ _____ _____ _____	☐ Chicken Pox ☐ Measles ☐ Shingles ☐ German Measles ☐ Mumps Further Detail: _____ _____ _____

Does your child need to take medication during program hours? ☐ Yes ☐ No **If yes please see Director for a written medication form.**

Is child allergic to any food, or medications/drugs other than those shown above?

_____

List any/all Medications child is currently taking:

_____

Is child on a special diet? If so, explain:

_____

Should child be restricted in recreation or swimming? In what way?

_____

Has child been under any medical care within the past three months? If so, explain:

_____

Mental and/or emotional growth normal for child's age?

_____

Anything else we should know about your child?

_____

MEDICAL FORM (continued)