**Health Information**

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| **Child’s First Name:** |  |
| **Child’s Last Name:** |  |

**Parent’s names**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency phone**#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Allergies** | | |
| Are there any allergies we should be aware of? Yes  No | | |
| If yes, please list: |  | |
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| In the event of an allergic reaction, what actions should VBS staff be expected to take? | | |
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| **Medical Issues or Special Needs** | | | |
| Are there any medical or special needs that our VBS staff need to be aware of regarding your child? | | | |
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| **Dietary Restrictions** | | |
| Snack will be provided on a daily basis. Does your child have any dietary restrictions that we need to be aware of? | | |
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**Medical Release**

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| Yes  No | I give my permission for the VBS staff to administer basic first aid to my child (named above in the event of an injury. I understand that VBS staff will contact emergency services in the event of a significant injury and all expenses for such emergency services will be paid by me. |
|  |  |
| Yes  No | In **emergencies** requiring immediate medical attention, my child will be taken to the **nearest hospital emergency room**. My signature authorizes the responsible person at the program to have my child transported to that hospital. I understand that all expenses for such emergency services will be paid by me. |

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| ***Signature of Parent/Guardian*** |
|  |
| ***Date*** |