**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: |  |
|  |  |
| 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*** |