

## Health Record Form

Child's Name	Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F
		Gender
Contact Parent's/Guardian's Name	Additional Contact Parent's/Guardian's Name	
Phone Number	Alternate Phone Number	Phone Number
		Alternate Phone Number
Address		Address
City, State ZIP Code	City, State ZIP Code	

### Alternative Emergency Contacts

Primary Emergency Contact	Secondary Emergency Contact
Phone Number	Phone Number
Alternate Phone Number	Alternate Phone Number

### Medical Information

Is this child is covered by family medical/hospital insurance? Yes No

Insurance Company	Policy Number	Subscriber Number	Insurance Company Phone Number
Name of child's primary doctor(s)	Phone Number		
Name of dentist(s)	Phone Number		
Name of orthodontist(s)	Phone Number		

### Allergies and Diet

Does this child have any known allergies?  Yes  No  
This child is allergic to:  Food  Medications  Environment (insect stings, hay fever, etc.)  Other

Please describe what this child is allergic to and the reaction seen.

In the case of food allergies, please describe any special food needs outside of a regular diet.

Please indicate action to be taken and any medication to be administered in case of an allergic reaction (mild or severe)

Does the child have an EpiPen?  Yes  No (If yes, please ensure you fill out an Allergy Action Plan)

### Restrictions

I have reviewed the program of the class and feel my child can participate:  without restrictions  with the following restrictions or adaptations:

### Mental, Emotional, and Social Health

Has the child ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?  Yes  No

Has the child ever been treated for emotional or behavioral difficulties or an eating disorder?  Yes  No

During the past 12 months, has the child seen a professional to address mental/emotional health concerns?  Yes  No

Has the child had a significant life event that continues to affect the camper's life?  Yes  No

We encourage you to explain any Yes answers or provide any additional information about the child that you think is important or that will help us to better teach them:

### Parent/Guardian Authorization for Health Care

This health history is correct and accurately reflects the health status of the child to whom it pertains. My child has permission to participate in all class activities except as noted by me/or an examining physician. If I cannot be reached in an emergency, I give permission to Atomic Adventures LLC to get my child to an emergency room in the most expedient manner possible. Additionally, I give permission for a physician selected by Atomic Adventures LLC to hospitalize and secure proper treatment for my child, including but not limited to ordering injections, anesthesia, surgery, x-rays and other tests related to the health of my child. I understand this information on this form will be shared on a "need to know" basis with Atomic Adventures LLC staff. I give permission to photocopy this form. In addition, Atomic Adventures LLC has permission to obtain a copy of child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status in the event of an emergency.

Signature of Custodial Parent/Guardian	Date	Relationship to Child
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