



**MERRIMACK PARKS & RECREATION
HEALTH HISTORY & MEDICAL AUTHORIZATION FORM**



Child's Last Name: _____

Child's First Name: _____

Health & Medications: The following information is required so that we are fully aware of any health concerns or limitations pertaining to your child. Per NH State Law, in addition to this form, all Campers must submit a record of immunizations and a record of a physical from within the past 24 months in order to attend Camp.

Check Health Status	No	Yes
Allergies (environmental, food or medication)		
Asthma		
Diabetes		
Dietary Restrictions		

Check Health Status	No	Yes
Seizure Disorder		
Inhaler		
Epi Pen		
Prescribed medication		

If you checked "YES" in any of the boxes above, please list any details related to that response in the space below.

Are there any activities that your child should not participate in? _____

Is there anything else that we should know about your child? _____

Pediatrician's Name: _____ Pediatrician's Telephone Number: _____

Medical Insurer/Health Plan Name: _____ Group/Policy #: _____

Name of Insured: _____ Relationship to Camper: _____

Over the Counter Medication Release: (Please initial each approved Over-The-Counter medication)

I authorize the Camp Medical Staff to provide the following over the counter medications if deemed necessary. Parents will be notified of any medication that is administered to their child. ___ Acetaminophen ___ Benadryl ___ Ibuprofen

EMERGENCY CONTACT INFORMATION

In the event of an emergency, we will always contact the parents/guardian first. However, if we are unable to reach you, please list the full names of all persons authorized by you to **pick up your child** from Naticook Day Camp.

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE
1. _____			
2. _____			
3. _____			
4. _____			

*** **NO** Camper will be released to anyone other than the individuals listed above. This form may be amended by Custodial Parent(s)/Legal Guardian(s) in person at the Day Camp Office as needed.

PERMISSION TO TREAT: I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for staff of the Parks and Recreation Department to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the staff of the Parks and Recreation Department to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care. It is understood that this authorization is given in advance of any such medical treatment, and that Parks and Recreation staff will contact me as soon as possible in the event such treatment is necessary, but is given to provide authority and power on the part of the staff of the Parks and Recreation Department in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel. I, the Minor's parent or legal guardian have read this form and understand its terms and I execute it voluntarily and with full knowledge of its significance.

Parent/Guardian Signature: _____

Date: _____