Health Record Form

Child's Name | Date of Birth | ☐ M ☐ 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 | Alternate Phone Number | 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:

Immunization History

Please provide the month and year for each immunization. An attached copy of your child's immunization record from your healthcare provider is also acceptable.

Diphtheria, tetanus, pertussis (DTaP) or (TdaP): Dose 1_____ Dose 2_____ Dose 3_____ Dose 4_____ Dose 5_____

Tetanus Booster (dT) or (TdaP): Most Recent Dose_____

Mumps, measles, rubella (MMR): Dose 1_____ Dose 2_____ Most Recent Dose_____

Polio (IPV): Dose 1_____ Dose 2_____ Dose 3_____ Dose 4_____ Most Recent Dose_____

Haemophilus influenza type B (HIB): Dose 1_____ Dose 2_____ Dose 3_____ Dose 4_____

Pneumococcal (PCV): Dose 1_____ Dose 2_____ Dose 3_____ Dose 4_____

Hepatitis A: Dose 1_____ Dose 2_____

Hepatitis B: Dose 1_____ Dose 2_____ Dose 3_____

Varicella (chicken pox): Dose 1_____ Dose 2_____

Meningococcal meningitis (MCV4): Dose 1_____

Tuberculosis (TB) test: Date_____ ☐ Negative ☐ Positive

☐ My child has been fully immunized and I have provided immunization record information.

Signature of Custodial Parent/Guardian | Date | Relationship to Child

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

Please explain any Yes answers or any additional information about the child's health that you think is important or that may affect their ability to fully participate in the class.

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 Katy Robotics Academy to get my child to an emergency room in the most expedient manner possible. Additionally, I give permission for a physician selected by Katy Robotics Academy 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 Katy Robotics Academy staff. I give permission to photocopy this form. In addition, Katy Robotics Academy 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