This side to be completed by parent/guardian. Please print/type. Return fully completed forms on the first day of class.

Child Name:_____ Birthdate _____ Sex____ Age _____
Parent/Guardian_____
Phone (_____)_____
Home Address _____City_____ State_____ Zip_____
Bus. # (_____)_____ Cell# (____) _____ Email_____

IF PARENT NOT AVAILABLE IN AN EMERGENCY, NOTIFY

Name_____Relationship_____
Phone (_____)_____
Bus. # (____)_____ Cell# (____)_____ Address_____
HEALTH HISTORY - (CHECK - GIVING APPROXIMATE DATES)
Has/Does the Child: Write in Y/N

1. Had any recent injury or infectious disease? 2. Have a chronic or recurring illness/condition? 3. Ever been hospitalized? 4. Ever had surgery? 5. Have frequent headaches? 6. Ever had a head injury? 7. Ever been knocked unconscious? 8. Wear glasses, contacts or protective eye wear? 9. Ever had frequent ear infections? 10.Ever passed out during or after exercise? 11.Ever been dizzy during or after exercise? 12.Ever had a seizure? 13.Ever had chest pain during or after exercise? 14.Ever had high blood pressure?	15. Ever been diagnosed with a heart murmur? 16. Ever had back problems? 17. Ever had problems with joints(e.g. knees ankles)? 18. Have an orthodontic appliance? 19. Have any skin problems (e.g itching, rash, acne)? 20. Have diabetes? 21. Have asthma? 22. Had mononucleosis in the past 12 months? 23. Had problems with diarrhea/constipation? 24. Have problems with sleepwalking? 25. If Female have abnormal menstrual history? 26. Have history of bed--wetting? 27. Ever had an eating disorder? 28. Ever had emotional difficulty for which profe

HAS THE CHILD HAD ANY OF THE FOLLOWING? ALLERGIES:

____ MEASLES _____ HEPATITIS A ____MUMPS _____ ASTHMA ____ INSECT STINGS
____ CHICKEN POX _____ HEPATITIS B ____OTHER _____HAY FEVER ____PENICILLIN _____PEANUTS
____GERMAN MEASLES _____ HEPATITIS C _____ POISON IVY ____OTHER DRUGS
Please explain any "YES" Answers!_____
_____ Any specific activities to be encouraged or limited by physician's advice
_____
_____ Dietary modification
_____ Current medications (send with instructions)_____
IMPORTANT: THIS BOX MUST BE COMPLETED!
I hereby give permission to the medical personnel selected by the After3 Staff to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes: and to provide or arrange related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by After3 to secure and administer treatment including hospitalization, for the person named above. This complete form may be photocopied for trips out of camp.

Signed_____Date_____ _____

After3's Permission and Pick-up Authorization Form

After3's staff has permission to treat my child for minor injuries. In the event of an emergency, I hereby grant After3's staff permission to bring my child to be treated at a hospital emergency room. I hereby give permission for my child to participate in all after-school related photography and video footage which can be used for marketing purposes. I hereby agree to all payment and behavioral policies.

Pick up Authorization:

I authorize After3 to allow the following person(s) to pick-up my child_____ from after-school. This authorization will remain in effect until I remove any names from the list.

Name: _____	Phone: _____	Relation: _____
Name: _____	Phone: _____	Relation: _____
Name: _____	Phone: _____	Relation: _____
Name: _____	Phone: _____	Relation: _____

Parent's Signature:

_____Date: _____