

PARENT CONSENT
(Please complete legibly and in ink)

I hereby give permission to my child to participate in the Ticonderoga Youth Commission Summer Activities.

I will not hold the Town of Ticonderoga, Youth Commission members, The Youth Commission Recreation Supervisor/Director, Chaperones, nor the Ticonderoga School District responsible for any accident or injury to my child.

Child Name	Grade	Date of Birth
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Parent/Guardian Signature

CHILD'S HEALTH SURVEY

Name of Parent/Guardian: _____

Phone: _____ Address: _____

Alternate #: _____

Emergency Contact & Phone: _____

Does your child have any of the following illnesses? (Please check all that apply)

- | | | |
|------------------|-----------------------|---------------------------|
| _____ Allergies | _____ Diabetes | _____ Heart Disease |
| _____ Asthma | _____ Discharging Ear | _____ High Blood Pressure |
| _____ Bronchitis | _____ Epilepsy | _____ Recent Surgery |

Explain each of the items checked above: _____

Date of Last Tetanus Toxoid Vaccine received _____

EMERGENCY CARE PERMISSION FORM

In the event your child may need emergency treatment, he/she will be taken to the nearest hospital. Below is a form, which will allow the hospital to administer proper treatment. Upon receipt of the completed form, we will retain it in our files for presentation to the hospital if need arises.

I hereby grant permission to administer emergency care, including Tetanus and Toxoid vaccine if necessary to my son/daughter _____. I accept responsibility for all Medical Expense.

Signature	Date
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Relationship to Child

HEALTH RECORD

Child's Name _____ Age _____ D.O.B. _____

Address _____

Phone: _____
Parent or Guardian _____

Emergency Contact if Parents can NOT be reached _____ Phone Number _____
YES NO YES NO

Allergies/Hay Fever			Elevated Blood Pressure		
Bee Sting Allergy			Headaches		
Asthma			Head Injury/Concussion		
Bladder Kidney Problem/Injury			Heart Problem/Murmur - pains		
Chicken Pox			Hepatitis		
Constipation			Measles/Mumps		
Convulsions/Seizures			Nose Bleeds/Frequent or Severe		
Fainting Spells			Ankle Injury		
Frequent Colds			Back Pain/Injury		
Frequent Sore Throat			Fracture-Dislocation Bones/Joint		
Diabetes			Knee Pain/Injury		
Ear Problem/Hearing Loss			Neck Injury		
Eye Problem/Vision Loss			Nose Fracture		
Injury to Spleen			Ivy, Oak or Sumac Poisoning		
Joint Sprain/Ligament tear/pull			Tetanus Toxoid		
One Kidney			One Testicle		
Hospitalized in last 6 months			Orthodontic Appliances		
Taking any Medication Now			Capped Teeth		
Wear Glasses			Wear Contact Lenses		

PLEASE ADVISE US IMMEDIATELY OF ANY CHANGES TO ANYTHING ON THIS FORM
 *In Case if any EMERGENCY, I give permission to the Physician selected by the Director, to administer proper treatment. Every effort will be made to contact the parents in the event of the emergency.

Parent/Guardian Signature _____ Date _____

I give permission to my child to participate in the Ticonderoga Program. I understand that my insurance is the primary insurance and the Town's insurance is the secondary. The Town of Ticonderoga is NOT responsible for any accidents of injuries.

Parent Signature _____ Date _____

**CONFIDENTIAL
MEDICAL HISTORY**

Please fill in the chart below or attach a copy of your child's shot records

Dates of Immunizations

Diphtheria	
Measles	
Mumps	
Polio	
Rubella	
Tetanus	
Hepatitis	

REQUIRED MEDICATION

PLEASE REMEMBER
ALL MEDICINE MUST BE LABELED WITH:

Child's Name	Name of Medication	Dosage
Time Given	If Refrigeration is needed	Special Conditions
	Instructions	

YOUR CHILD MUST KNOW THE FOLLOWING IN ORDER TO HAVE
MEDICATION AT THE PROGRAM

Recognize Name	Recognize Medication	Dosage
Know what it is for	Know how to take it	Know when taken

NAME OF MEDICATION: _____

SPECIFIC INSTRUCTIONS: _____

Child's Name

Parent's Name