STORROWTON VILLAGE Museum
EASTERN STATES Exposition

Pioneer Kids Week

HEALTH / MEDICATION INFORMATION

(2 pages)

Child's name _____ M / F Age ____ DOB _____

Address/City/State/Zip_____

Parent/Guardian _____ Phone _____

Child's Physician _____ Phone _____

Emergency Contact _____ Phone _____

IMMUNIZATION HISTORY

Fill out or attach immunization history from pediatrician

Vaccine	**Dates (Month/Year)**				
DTP	_____	_____	_____	_____	_____
TD (tetanus/diptheria)	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	
MMR	_____	_____			
or Measels	_____	_____			
or Mumps	_____	_____			
or Rubella	_____	_____			
Haemophilus Influenza B	_____	_____	_____	_____	
Hepatitis B	_____	_____	_____		
Varicella (chicken pox)	_____	_____			
TB Mantoux test	_____	Results: (circle)	Positive	Negative	

DOES THIS CHILD:

Check if "yes" and please explain

- Have a known allergy or health condition which may affect his/her ability to participate in any activities?

  _____

- Have a known allergy or sensitivity to a particular food or medication?

  _____

- Been exposed to any contagious disease within the past month?

  _____

- Been out of the country within 2 weeks prior to attending this program?

  _____

- Have any behavioral, physical, emotional, or mental health issues of which our staff should be aware?

  _____
  _____

- Take a prescribed medication or treatment of any kind?

  _____

- Will child require medication to be given while at Storrowton Village? Yes ____ No ____

MY CHILD TAKES A PRESCRIBED MEDICATION OR TREATMENT

Medication _____ Prescription ____ Non-Prescription ____

Dosage _____ Directions for storage _____

Date(s) and time(s) for medication to be given: _____

Reason for medication _____

Possible side effects _____

Prescribing physician _____ Phone _____

PARENT/GUARDIAN AUTHORIZATION

This health history is correct and complete to the best of my knowledge. If applicable, I authorize Storrowton Village Museum staff to administer the medication I have provided for my child as indicated above.

In case of emergency, I give consent for any necessary examination and/or medical treatment for my child as prescribed by an attending physician. In the event that I cannot be reached in an emergency, I give permission to Storrowton Village to arrange necessary transportation for my child to the closest emergency facility. I agree to be responsible for all medical expenses incurred on behalf of my child.

Signature _____ Date _____

Printed Name _____ Phone _____