

Participant Health Questionnaire

Participant Name: _____

Address: _____

Telephone # _____ D.O.B. _____

School: _____ Grade: _____

Emergency Contact: _____

Relation: _____ Telephone #: _____

Please answer **yes** or **no** to the following questions based on your **child's** current or past medical history. Has your child ever or does your child currently:

	YES	NO
1. Suffer from Chronic Medical Condition? (asthma, diabetes, epilepsy, etc...)	_____	_____
2. Take prescription medication(s) on a daily basis?	_____	_____
3. Have any allergies? (foods, medications etc...)	_____	_____
4. Utilize special protection or corrective equipment during sports activities?	_____	_____
5. Had a seizure?	_____	_____

If you have answered yes to any of the above questions, please provide an explanation below:

Does your child suffer from any illnesses, conditions or injuries that our staff should be informed of to ensure the safety of your child and all attendees while participating in these activities?

I understand that the Civic Council and it's Officers, management, staff and volunteers respectively, have requested this authorization to release or disclose the personal health information described above to make certain decisions about your child's health and ability to participate in certain programs with our Sensational programming. I further understand that the Civic Council is not a health care provider or health plan covered by federal HIPAA privacy regulations and the information described above may not be redisclosed and may not continue to be protected by the Federal; HIPAA privacy regulations.

My Signature below indicates the acceptance, understanding and acknowledgement of all my responsibilities as a parent/guardian of my child(ren) as (a) participant(s) in the Central Islip Civic Council Sensational Program.

Parent/Guardian Signature: _____

Today's Date: _____