

HEALTH HISTORY FORM: KALEIDOSCOPE IN ACTION 2012

Important: If any information is missing, this form will be returned to you.

Name of child: _____ Birthday: ____/____/____
Address _____ Phone _____

Kaleidoscope in Action course codes (Please circle your child's courses.)

26-Ballet 28-Golf 52-Dance 58-Jump Rope 78-Hoop Stars 87-Golf
103-Soccer 163-Dance 168-Sports Camp

Child's Weight: _____ pounds

Does this child have any current or past medical issues? ___Yes ___No

If yes, please describe:

Does this child take any medications at home? ___Yes ___No

If yes, please describe:

Does this child have any known allergies to foods or medications? ___Yes ___No

If yes, please describe:

Will this child require any medication at Kaleidoscope this summer? ___Yes ___No

If yes, please describe:

Note: A separate medication authorization form will be required for this purpose. Contact the Kaleidoscope office (978-475-1422) to obtain this paperwork or obtain from website.

Child's Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone : _____

Insurance Company: _____

Policy Holder: _____

Policy Number: _____

Emergency Contact Information: In the event that we cannot reach you, please identify at least two emergency contacts (names and phone numbers):

1)

2)

Emergency Consent Form: I, the undersigned, will not hold Kaleidoscope, its agents, servants, or employees responsible for any accidents incurred during participation in the Kaleidoscope program. If my doctor cannot be reached or in case of emergency, consent is hereby given for medical treatment and/or surgical care as recommended by physician or hospital.

(parent's signature)

(date)

Please mail this form (prior to May 20) to: Kaleidoscope, Box 506, Andover, MA 01810. You can also fax the form to (978) 475-1422. Thank you.