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Wheaton Park District

2025-2026 Health History and Emergency Form

Name of Program:_____ Session:_____

Name_____ Birthday_____ Age_____ Grade in Fall_____

Home Address_____ City_____ Zip Code_____

Parent/Legal Guardian_____ Phone Number_____

Address_____ City_____ Zip Code_____
(If different from address above)

Work Phone:_____ Cell Phone:_____

Second Parent/Legal Guardian_____ Phone Number_____

Address_____ City_____ Zip Code_____
(If different from address above)

Work Phone:_____ Cell Phone:_____

If not available in an emergency, notify:

Name_____ Relationship_____

Cell:_____ Home Number:_____

Address_____ City_____ Zip Code_____

Insurance Information

Is the participant covered by family medical/hospital insurance? ___yes ___no

If yes, indicate carrier or plan name_____ Group #_____

Carrier Address_____ City_____ Zip Code_____

Name of Insured_____ Relationship to participant_____

Physician Information

Name of Physician_____ Telephone_____

Address_____ City_____ Zip Code_____

Name of Dentist_____ Telephone_____

Address_____ City_____ Zip Code_____

Authorization for Emergency Medical Treatment

I authorize the Wheaton Park District to take action as necessary in case of an emergency.

_____ _____

Date Signature of Parent or Guardian

Please see back side of form for health information

Health History

The parent/legal guardian must fill in the following information. The intent of this information is to provide staff the background for appropriate care. Keep a copy of the completed form for your records.

ALLERGIES – List all known **Describe Reaction and Management of the Reaction**
Medication Allergies (List)

_____ _____

Food Allergies (List)

_____ _____

Other Allergies (List) – include insect stings, hay fever, asthma, animal dander, bug spray, etc.

_____ _____
_____ _____

Restrictions (The following restrictions apply to this individual)
Does not eat:

Peanuts **Tree Nuts** **Pork** **Poultry** **Seafood** **Eggs** **Dairy** **Other**

Please describe other:_____

General Questions (Explain "yes" answers below)

1. Had any recent injury, illness or infectious disease?	Yes	No	7. Ever had back problems?	Yes	No
2. Have a chronic or recurring illness/condition?	Yes	No	8. Ever had problems with joints?	Yes	No
3. Ever had a head injury?	Yes	No	9. Have any skin problems (rash, itching. Etc)	Yes	No
4. Ever been knocked unconscious?	Yes	No	10. Have diabetes?	Yes	No
5. Wear glasses contacts or protective eyewear?	Yes	No	11. Have frequent headaches?	Yes	No
6. Ever been diagnosed with a heart murmur?	Yes	No	12.Ever have frequent ear infections?	Yes	No

Please explain any "yes" answers, noting the number of the question (s).

_____

My child is up-to-date on his/her immunizations: ____yes ____no

What is the month/year of your child's tetanus shot? _____(mandatory)

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the staff should be aware:

_____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary):

_____

My child is authorized to be picked up by the following person(s) from the program: (ID must be provided by person picking up)

1. _____ Relationship_____Phone # _____
2. _____ Relationship_____Phone # _____
3. _____ Relationship_____Phone # _____