Bluffton-Harrison MSD
Summer Childcare Program 2017

*** Please complete and return before the end of the school year.**

Student name: ____________________________ Age _______ Birth date ________________
Parent/Guardian name_________________________________ Emergency contact number_____________

Medical History/Conditions
For each of the following conditions please circle "Yes" or "No". For "Yes" answers, please list any medications taken or any special care for the condition. If needed, please use the back of this page for additional information. **If the student takes any medication, please fill out the medication section on the back of this page.**

	Condition	Yes/No	Medication/Special Care/Notes
1.	Acid reflux/GERD/frequent vomiting	Yes/No	____________________
2.	ADD/ADHD (Attention Deficit Hyperactivity Disorder)	Yes/No	____________________
3.	Asthma (If yes, please see nurse for school instructions)	Yes/No	____________________
4.	Autism Spectrum Disorder	Yes/No	____________________
5.	Bee /Insect sting allergy*	Yes/No	____________________
6.	Bone, joint, or muscle disorders/fractures	Yes/No	____________________
7.	Bladder or Kidney concerns/control problems	Yes/No	____________________
8.	Bowel concerns (constipation, loose stools)	Yes/No	____________________
9.	Cerebral Palsy (C.P.)/Neurological disorders	Yes/No	____________________
10.	Diabetes (If yes, please see nurse for school instructions)	Yes/No	____________________
11.	Digestive concerns/special diet/tube fed	Yes/No	____________________
12.	Ear or hearing concerns	Yes/No	____________________
13.	Emotional/psychological	Yes/No	____________________
14.	Epilepsy/Seizure disorder	Yes/No	____________________
15.	Eye or vision concerns	Yes/No	____________________
16.	Food allergy**/Intolerance (milk, dairy products, etc.)	Yes/No	____________________
17.	Genetic disorder/Chromosome disorder/Syndrome	Yes/No	____________________
18.	Heart/Congenital Heart Defect/Heart Surgery	Yes/No	____________________
19.	Headaches (frequent, migraines, sinus)	Yes/No	____________________
20.	Medical Equipment (feeding tube, wheelchair, etc)	Yes/No	____________________
21.	Pollen, dust, environmental allergies	Yes/No	____________________
22.	Shunt/hydrocephalus	Yes/No	____________________

Allergies
Please list the type of reaction and medication/treatment needed for each allergy:

Allergy	Type of Reaction	Medication/Treatment Needed
____________	____________________	____________________
____________	____________________	____________________
____________	____________________	____________________

Please complete the back side of this form.

Medications
Does this student take any medication (prescribed and/or over-the-counter/OTC) at home? Yes/ No

Medication Name	Dose and Time(s) Taken	Reason for Medication
____________________	________________________________	____________________________
____________________	________________________________	____________________________
____________________	________________________________	____________________________
____________________	________________________________	____________________________

***Note: BH MSD does not employ a Registered Nurse for the summer childcare program. Therefore no medical services will be provided other than basic first aid given by the childcare providers. If your child takes prescription medications, please administer them before and/or after childcare hours and as directed by the physician. If your child requires emergency medication, such as an inhaler or Epi Pen, it will be the parent/guardian's responsibility to contact the childcare providers and provide appropriate training to administer the medication. A consent form will be signed by the parent and the childcare provider(s) who the parent has deemed responsible to administer the medication. In an emergency situation, BH MSD childcare providers will call 911 immediately and then notify the parent/guardian.**

Other information
Please give any additional information that would be helpful for the staff at school to know to keep the student safe and healthy:

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____
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Parent/Guardian Signature____________________________ Date ________________

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