



# Bourbonnais Township Park District

## Health and Medical History Form

To be filled out by parent or guardian, or adult participant. Please print in ink.

Participant Name \_\_\_\_\_ Phone \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home address \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender    M    F

Doctors Name \_\_\_\_\_ Phone \_\_\_\_\_

Hospital preference \_\_\_\_\_

Please notify the following person(s) in the event of an emergency.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Does the participant have any restriction of activity for medical reasons? Explain:

\_\_\_\_\_  
\_\_\_\_\_

Please list any medical problems that the Park District should be aware of.

\_\_\_\_\_  
\_\_\_\_\_

Does the participant have any allergies to food, medicine, insects, plants or other? Explain:

\_\_\_\_\_  
\_\_\_\_\_

Is the participant under any medication at the time of the program? If so, list out the date for the medicine term, the name of the medication, name of the administering physician, and schedule of dosage to be administered under supervision. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**By signing this form, I am providing written authorization for the administration of medication(s) that are indicated hereinabove pursuant to the schedule as outlined. A more detailed schedule of administration may be requested and will be provided in turn.**

**In case of an emergency, I understand that every effort will be made to contact me (if an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or me, if an adult).**

\_\_\_\_\_  
**Signature of parent/guardian or adult participant**

\_\_\_\_\_  
**Date**