

HEALTH HISTORY & EMERGENCY FORM

City of Los Angeles
Department of
Recreation & Parks



**CHEVY CHASE
RECREATION CENTER**
4165 Chevy Chase Drive
Los Angeles, CA. 90039
(818)550-1453

Child's Name _____ Age _____ Birth Date _____
Address _____ City _____ Zip _____
Parent/Guardian _____ Phone _____ Work Phone _____
Parent/Guardian _____ Phone _____ Work Phone _____
Relative (Name) _____ Phone _____
Relative (Name) _____ Phone _____
Doctor (Name) _____ Medical Record # _____ Phone _____

PLEASE CHECK IF THE CAMPER HAS HAD ANY OF THE FOLLOWING: YEAR OF LAST IMMUNIZATION OR BOOSTER

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Mumps	<input type="checkbox"/> Frequent Colds	_____ Tetanus
<input type="checkbox"/> Measles	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Headaches	_____ Diphtheria
<input type="checkbox"/> German Measles	<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Rheumatic Fever	_____ Whooping Cough
<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Fainting	<input type="checkbox"/> Scarlet Fever	_____ Polio
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diphtheria	_____ Mumps
<input type="checkbox"/> Asthma	<input type="checkbox"/> Stomach Upset	<input type="checkbox"/> Heart Trouble	_____ German Measles
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Skin Rash	<input type="checkbox"/> Nose Bleeds	_____ Hepatitis

Allergies _____ / _____ / _____ Allergy Medication _____
Child's Name _____ Age _____ Birth Date _____

Asthma (or Hay Fever) _____ Medication _____ Serious Injury or Illness _____
Has the Child received medical treatment during the past year? yes no
Date _____ Reason _____
Does child take medication at present? yes no
If so, what is the medication? _____

Prescription Drugs must be in original pharmacy containers (no modifications)
DIRECTOR MUST BE NOTIFIED IF MEDICINE IS BROUGHT TO CENTER

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AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR AT AUTHORIZED HOSPITAL IN CASE OF EMERGENCY, ILLNESS OR ACCIDENT

(I), (We), the undersigned parent(s) of _____, a minor, do hereby authorize The Directors of **Chevy Chase Recreation Center** as agent(s) for the undersigned to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provision of the Medical Practice Act on the medical staff of a licensed hospital whether such diagnosis or treatment is rendered at the office of said physician or at the said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but it is given to provide authority and power on the part of aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization shall remain effective until _____ unless sooner revoked in writing and delivered to said agent(s).

PARENT PERMISSION: I hereby authorize permission for my son/daughter _____ to travel (bus, van, train, walking, etc.) to any field trip or outing with The City of Los Angeles Department of Recreation and Parks and I further agree to relieve its official agents or employees from any liability in connection with this authorization.

FATHER NAME (please print): _____ FATHER SIGNATURE: _____ DATED: _____

MOTHER NAME (please print): _____ MOTHER SIGNATURE: _____ DATED: _____

LEGAL GUARDIAN (please print): _____ LEGAL GUARDIAN SIGNATURE: _____ DATED: _____

NOTE: The signing of this Consent to Treatment Authorization is not mandatory but it is requested for your protection.

IF ANY INFORMATION ON THIS FORM CHANGES, IMMEDIATELY NOTIFY THE DIRECTOR IN WRITING.

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