HEALTH HISTORY & EMERGENCY FORM

City of Los Angeles
Department of
Recreation & Parks

HOLLENBECK
RECREATION CENTER
415 S.ST Louis Street
Los Angeles, CA. 90033
(323) 261-0113

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:

☐ Chicken Pox	☐ Mumps	☐ Frequent Colds	____ Tetanus
☐ Measles	☐ Sinus Trouble	☐ Headaches	____ Diphtheria
☐ German Measles	☐ Ear Infection	☐ Rheumatic Fever	____ Whooping Cough
☐ Tonsillitis	☐ Fainting	☐ Scarlet Fever	____ Polio
☐ Appendicitis	☐ Constipation	☐ Diphtheria	____ Mumps
☐ Asthma	☐ Stomach Upset	☐ Heart Trouble	____ German Measles
☐ Hay Fever	☐ Skin Rash	☐ Nose Bleeds	____ Hepatitis

YEAR OF LAST IMMUNIZATION OR BOOSTER

Allergies _____ / _____ / _____Allergy Medication _____
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

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 **Hollenbeck 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.