

# Hopkinsville YMCA Child Information Form

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair color: \_\_\_\_\_ Eye color: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Parent Information

Mother's Name: \_\_\_\_\_  
Address (if different): \_\_\_\_\_ Home phone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Father's Name: \_\_\_\_\_  
Address (if different): \_\_\_\_\_ Home phone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_

## Emergency Information

List any special needs that your child has that we should be aware of (allergies, medical, etc.) \_\_\_\_\_

## **Person authorized to act for parent in case of emergency:**

Name \_\_\_\_\_  
Day phone : \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Child's Physician: \_\_\_\_\_  
Physician's phone: \_\_\_\_\_ Hospital preference: \_\_\_\_\_

## Health History Checklist

Yes	No	has your child ever been hospitalized overnight
Yes	No	does your child take any medication
Yes	No	allergies or reactions to medicine, DPT, shot or insects
Yes	No	asthma or wheezing
Yes	No	speech or hearing problems
Yes	No	eye or sight problems
Yes	No	bladder or kidney infections
Yes	No	seizures, fits or shaking spells
Yes	No	heat problems
Yes	No	ever had a bumpy, swollen reaction to the TB skin test
Yes	No	has your child ever been with anyone with TB
Yes	No	is your child a hemophiliac (free bleeder)
Yes	No	have tubes in his/her ears
Yes	No	have learning disabilities
Yes	No	are the immunization records up to date
Yes	No	does your child get along with other children
Yes	No	is he/she usually happy
Yes	No	is your child able to play as hard as other children

We ask that you help us teach the basic guidelines which are: respect the start: respect the children and respect the property.

My child has my permission to participate in this program and I understand I have to provide my own accident insurance for him/her. In my absence, I authorize the YMCA staff to give approval for emergency medical care, including but not limited to basic CPR and First Aid.

Parent/Guardian Name: \_\_\_\_\_ (please print)

Parent /Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_