



BOYS & GIRLS CLUB
OF MERCER COUNTY

Medical Declaration Statement for Members

Child's Name: _____

Date of Birth: _____ Grade: _____

1. Is your child under any medical/physical restrictions?

Yes _____ No _____

If yes, check all that apply.

- | | | | |
|--------------|-------|--------|-------|
| Asthma | _____ | Others | _____ |
| Hearing Loss | _____ | | _____ |
| Diabetes | _____ | | _____ |
| Seizures | _____ | | _____ |

2. Is your child taking any medications?

Yes _____ No _____

a. If yes, please list:

b. WILL YOUR CHILD BE TAKING ANY MEDICATION(S) REGULARLY WHILE ATTENDING PROGRAM?

yes _____ NO _____

If yes, you need to complete a CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS form.

3. Is your child allergic to any: (Please list.)

a. Foods? No _____ Yes _____

b. Medications? No _____ Yes _____

c. Other? No _____ Yes _____

4. Family Health Care Provider

Name: _____

Telephone Number: _____

As a parent/ guardian of the above participating child, I certify that he/she is in good physical health, has no special medical needs (or I have completed a care form) and may participate in all program activities.

Parent/Guardian Signature: _____ Date: _____