Youth Program Health Information

Child's Name_____ _____

Last First Age

2nd Child _____ _____

Birth Dates 1.) _____ 2.) _____

Parent or Guardian_____ Phone_____

Home Street Address_____ Work Phone_____

Emergency Contact_____ Phone_____

Is your child allergic to bees? _____ Any food allergies?_____

Any other allergies or concerns? _____

____ **I have attached a copy of my children's immunization records.**

Or

____ **I give Johnsburg Central School permission to make a copy of my children's immunization records or letter of exemption for the Dept. of Health requirement to attend the Youth Program.**

In case of an emergency, I give permission to the Johnsburg Youth Program to secure medical treatment for the above child (children). Every effort will be made to contact the parents or guardian in the event of an emergency.

Signature_____ Date_____