**Springfield College East Campus**
**263 Alden Street**
**Springfield, MA 01109-3797**

# 2020 Emergency Contact & Health Record

**Child's Name**:_______________________________________________ Gender:___________
Last First M.I.

DOB:_________/______/______ Age:__________

**Parents/Guardian:**

Name:_______________________________________________ Relation to Child:_________________
Last First

Address:_______________________________________________________________
# Street Town/City State Zip Code

Phone (Home): (_______) ______-______ Phone (Work): (_______) ______-______Phone (Cell): (_____) ______-_______

Name:_______________________________________________ Relation to Child:_________________
Last First

Address (if different from above):_______________________________________________
# Street Town/City State Zip Code

Phone (Home): (_______) ______-______Phone (Work): (_______) ______-______Phone (Cell): (_____) ______-_______

**One Additional Emergency Contact:**

Name:_______________________________________________ Relation to Child:_________________
Last First

Address:_______________________________________________________________
# Street Town/City State Zip Code

Phone (Home): (_______) ______-______Phone (Work): (_______) ______-______Phone (Cell): (_____) ______-_______

**Health History: Provide dates and other information requested or indicate N/A (not applicable) if appropriate.**

| | | | | | |
|---|---|---|---|---|---|
| Ear Infections | _______ | Chicken Pox | _______ | Measles | _______ |
| Convulsions | _______ | German measles | _______ | Diabetes | _______ |
| Mumps | _______ | Bleeding disorder | ________ | Tuberculosis | ________ |

Allergies:_______________________________________________________________

Operations/Serious Injuries:_______________________________________________

Disability or chronic or recurring illness:__________________________________

Current medications:______________________________________________________

Family Medical Insurance Carrier:___________________________ Policy # ___________________

Name of Dentist/Orthodontist:______________________________ Phone #___________________

Name of Family Physician: _________________________________ Phone #___________________

**Signature of Parent/Guardian: ___________________________________ Date: _______________**

**IMPORTANT: Please contact the office at 750.5011 immediately if your child has been exposed to a communicable disease during or within three weeks prior to attendance.**

**Immunizations**: This section must be completed by a licensed health care provider or attach a copy of immunization documentation or alternative proof of immunity.

| **REQUIRED IMMUNIZATIONS** (Participants under 18 years of age) | **DATE (Month/Day/Year)** |
|---|---|
| **MMR** (1st dose age 12 months or older) | |
| **Measles #2 or MMR #2** (Given at age 4 – 6 years and at least 1 month after 1st dose) | |
| **Polio** (3 doses of OPV or IPV or 4 doses of mix IPV and OPV) | **#1**<br>**#2**<br>**#3**<br>**#4** |
| **Diptheria and Tetanus Toxoids and Pertussis** (4 doses of DTaP/DTP/DT/Td. Booster dose of Td required if more than 10 years since last dose) | **#1**<br>**#2**<br>**#3**<br>**#4**<br>**Booster** (if applicable) |
| **Hepatitis B** (3 doses if born on or after January 1, 1992) | **#1**<br>**#2**<br>**#3** |

LEAD SCREENING: ______________________________________________

Effective 3/01/90 Massachusetts State Law requires all children, regardless of risk, shall be screened at least once between the ages of 9-12 months and annually until the age of 48 months. Children who are determined to be at high risk for lead exposure must be screened every 6 months and 3 years and yearly from 3 years to 6 years. Children must present evidence of having been previously screened as a condition for entry to kindergarten.

**Physical Examination By a Physician:** This section must be completed by a physician or attach a copy of a physical examination conducted by a physician during the preceding 24 months.

**DATE OF MOST RECENT PHYSICAL EXAM:**______________________

| Height: | Eyes: | Abdomen: |
|---|---|---|
| Weight: | Vision: | Genitalia, Hernia: |
| BP: | Ears, Nose, Throat: | Musculoskeletal: |
| HCT or Hgb: | Heart: | Neurological Exam: |
| Urinalysis: | Lungs: | Skin: |

**Recommendation for Participation:**

- Is person capable of participating in active program(s)? Yes No
- Please explain any restriction(s) ______________________________
- Is person currently taking medication(s)?______________________________
- List any medications to be administered by ______________________________

______________________________________________

______________________________________________

Signature of Health Care Provider: ______________________________Date: ____________

Printed Name of Health Care Provider: ______________________________Phone: ____________

Office Address: ______________________________________________