

**Springfield College East Campus**  
**263 Alden Street**  
**Springfield, MA 01109-3797**  
**2019 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)
<b>MMR</b> (1 <sup>st</sup> dose age 12 months or older)	
<b>Measles #2 or MMR #2</b> (Given at age 4 – 6 years and at least 1 month after 1 <sup>st</sup> dose)	
<b>Polio</b> (3 doses of OPV or IPV or 4 doses of mix IPV and OPV)	#1 #2 #3 #4
<b>Diphtheria and Tetanus Toxoids and Pertussis</b> (4 doses of DTaP/DTP/DT/Td. Booster dose of Td required if more than 10 years since last dose)	#1 #2 #3 #4 Booster (if applicable)
<b>Hepatitis B</b> (3 doses if born on or after January 1, 1992)	#1 #2 #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: \_\_\_\_\_