

Participant's Name (last, first) _____ Date _____

Email Address _____

Contact's Email _____

**ZACK'S PLACE
HEALTH AND EMERGENCY CARE FORM**

General Information

Entering Grade _____ Male ___ Female ___ Age ___ Birth Date _____

Custodial Parent's/Guardian's Name: _____

Relationship to Participant: _____

Telephone (day) _____ (evening) _____

Home Address _____

2nd Guardian's Name & Relationship: _____

Telephone (home) _____ (cell) _____ (wk) _____

Home Address _____

Mailing Address _____

Emergency Contacts

If we cannot reach the Parent(s)/Guardian(s) listed above, please provide emergency contacts:

Name	Phone	Relationship
1. _____	_____	_____
2. _____	_____	_____

Pick-Up Authorization

Please list those who are authorized to pick up your participant.

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

Medical Information

Child's/Ward's Physician _____ Phone _____

Child's/Ward's Dentist _____ Phone _____

Health Insurance Company _____ Policy Number _____

Describe your participant's medical conditions and how they affect his/her ability to participate in certain activities _____

Medications _____

Please provide dates of your participant's most recent immunizations:

Measles _____ Mumps _____ Rubella _____ Polio _____

Date of last tetanus shot: _____ Has he/she had chicken pox? ___yes ___no

Does your participant suffer from any of the following? If so, please provide dates below.

___ Ear Infections	___ Reaction to Poison Ivy	___ Cramps
___ Frequent Colds	___ Diabetes	___ Psychiatric Treatment
___ Hypertension	___ Severe Sting Reactions	___ ADD/ADHD
___ Mononucleosis	___ Bleeding Disorder	___ Heart Disease
___ Hay fever	___ Food/Other Allergies	___ Epilepsy/Seizures
___ Penicillin Allergy	___ Asthma	___ Other (describe below)

Comments/Dates: _____

Does your participant need to carry a bee sting kit? ___yes ___no

If so, please be sure he or she knows how to use it and brings it to Zack's Place each day.

Due to the public nature of our site, we cannot guarantee that the area is peanut/nut free.

Special Needs

Describe your participant's special behavioral/physical needs. Please share information about his/her mental, emotional, and physical health that will enable us to better serve him/her, and describe effective strategies for addressing this need.

Parent/Guardian Authorization Statement

In the event that you are unable to reach a parent/guardian or emergency contact by phone while my child is at Zack's Place, I hereby authorize ZP Staff or medical personnel to take emergency measures as needed.

Signature _____ Date _____

ZP Release Statement

As a parent of _____ (child's/ward's name), I understand that:

- Although ZP staff will exercise many cautions to prevent mishaps (including adequate adult supervision, extreme care in potentially dangerous situations, clear communication with participants), injuries are still possible. Provided that adequate precautions have been taken by ZP staff, I will assume all risks of injury, hereby releasing and holding harmless Zack's Place, its employees or agents from liability for any such injury.

Parent's/Guardian's Signature _____ Date _____

Please submit Health and Emergency Care Form to:

Dail Frates
Executive Director
Zack's Place
P.O. Box 634
73 Central Street
Woodstock, VT 05091
(802) 457-5868