

I want to be in SMILE because:

Careers/jobs that interest me:

HEALTH AND MEDICAL RECORD FOR CLUB, ANNUAL ACTIVITIES AND FIELD TRIPS

Name of Child

School District

Grade

Please check all that apply to your child. If you check any conditions, please explain.

Asthma _____ Diabetes _____ Fainting _____ Convulsions _____
Heart Trouble _____ Bed Wetting _____ Sleepwalking _____ Nose bleeding _____
Other: _____

If my child becomes ill or injured when away from home during SMILE activities, you have my permission to seek medical treatment for him/her. I understand that I will be contacted immediately if medical treatment is necessary. List any known health concerns, such as allergies, that we need to know about. **Please fill in all blanks. If the statement does not apply to your child, write "none".**

Allergy or reaction to any medication, food, ect. _____ Please list _____
Allergy to bee sting; describe reaction _____
List any dietary restrictions for medical or religious reasons _____
Instructions for any medication child may bring to the activity _____
Describe any restrictions of activity for medical reasons _____
Describe any mental or emotional problems _____
Date of last tetanus inoculation (must be current) _____

NOTE TO PARENTS:

If your child has a special medical condition, a medical clearance from your family doctor is necessary. If no clearance is received, we reserve the right to not accept your child to the activity. Medication taken during the activities should be checked in with adult supervisor BEFORE the activity.

If you feel, there are any circumstances you would like to discuss with SMILE staff, please call or write to The SMILE Program office 401-874-2036 or cenglander@uri.edu. We would be glad to discuss it with you. Please feel free to discuss these matters with your child's SMILE teachers also.

In case of emergency, this will authorize physician and/or hospital to provide medical treatment:

Identification/Group # _____
Insurance Company _____ Policy # _____
Insured Person's Name _____ Relationship to child _____
Home Phone _____ Emergency Phone _____

By signing this form, you state that you have read and understood all of the information on all of the pages.

EMERGENCY CONTACT

If you cannot be reached in case of emergency, please list a contact number for a trusted adult.

NAME: _____ **RELATIONSHIP TO CHILD:** _____
PHONE NUMBER: _____

SIGNATURES

Parent (Guardian)Signature:

Date: