

2007-2008

The Powell House Youth Program  
524 Pitt Hall Road, Old Chatham, NY 12136-3410  
518-794-8811

**HEALTH RECORD, EMERGENCY CONTACTS, AND PARENTAL PERMISSION FORM**

As required by our local Department of Health, you must have this form filled out completely when you attend a Powell House youth conference. A completed form suffices for an entire program year (September to August). A medical exam is not required to complete this form.

- 1. NAME \_\_\_\_\_
- 2. BIRTHDATE \_\_\_\_\_
- 3. ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

**4. SPECIFIC PERMISSIONS**

<i>I give permission to the Powell House staff to give my child over the counter medications as necessary (e.g. Tylenol, antihistamine, etc...)</i>	yes	no
Parent or guardian signature _____ Date _____		
<i>I give permission for my child to take homeopathic remedies.</i>	yes	no
Parent or guardian signature _____ Date _____		
<i>My child has an epi-pen in case of:</i>		
Parent or guardian signature _____ Date _____		

**5. PERSONS TO CONTACT IN AN EMERGENCY**

Parent's name \_\_\_\_\_ Phone \_\_\_\_\_

Parent's name \_\_\_\_\_ Phone \_\_\_\_\_

(if the parents are not available)

Name \_\_\_\_\_ Relationship to youth \_\_\_\_\_

Name \_\_\_\_\_ Relationship to youth \_\_\_\_\_

Phone w/ area code \_\_\_\_\_ Phone w/ area code \_\_\_\_\_

**6. In case the above-named persons cannot be reached, I grant permission for the Powell House staff to provide and/or obtain emergency treatment for this youth and to act "In Locus Parentis". I also grant permission for off-campus trips as scheduled and supervised by Powell House staff.**

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

(The Chatham ambulance normally goes to Hudson. Depending on the circumstances, they may also go to Pittsfield or Albany for your convenience, depending on your direction. ) **If my child has to be transported to a hospital, I prefer that they go to:**

- 1. Columbia Memorial – Hudson, NY
- 2. Pittsfield, MA
- 3. -Albany, NY

7. DATE OF LAST PHYSICAL EXAMINATION \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

8. GENERAL HEALTH: EXCELLENT \_\_\_\_\_ GOOD \_\_\_\_\_ POOR \_\_\_\_\_

9. ANY RECENT ILLNESS, DISEASES, PHYSICAL, OR MENTAL IMPAIRMENTS? PLEASE EXPLAIN:

\_\_\_\_\_  
\_\_\_\_\_

10. DATE OF LAST TETANUS IMMUNIZATION OR BOOSTER SHOT \_\_\_\_\_

PLEASE LIST THE DATES FOR THE FOLLOWING:

DPT \_\_\_\_\_ MEASLES \_\_\_\_\_ RUBELLA \_\_\_\_\_ POLIO \_\_\_\_\_ MUMPS \_\_\_\_\_

11. PLEASE LIST ALL ALLERGIES (EVEN MINOR ONES - OF ANY KIND) AND EXPLAIN DETAILS OF SEVERITY, MEDICATION AND EMERGENCY PROCEDURES:

FEATHER PILLOWS \_\_\_\_\_

FOODS (PLEASE SPECIFY) \_\_\_\_\_

ASTHMA \_\_\_\_\_

HAY FEVER \_\_\_\_\_

BEE/WASP STINGS \_\_\_\_\_

ASPIRIN \_\_\_\_\_

PENICILLIN \_\_\_\_\_

OTHERS \_\_\_\_\_

12. PLEASE LIST ALL MEDICATIONS (INCLUDING DOSAGE AND FREQUENCY) USED REGULARLY. PLEASE MAKE SURE THESE MEDICATIONS AND OTHER MEDICATIONS THAT MAY BE TAKEN OCCASIONALLY ARE BROUGHT TO POWELL HOUSE.

\_\_\_\_\_  
\_\_\_\_\_

13. ARE THERE OTHER THINGS (E.G. STRONG FEARS, BED WETTING, RECENT CHANGES IN LIVING SITUATION) ABOUT WHICH STAFF SHOULD KNOW.

\_\_\_\_\_  
\_\_\_\_\_

14. HEALTH INSURANCE INFORMATION

CARRIER \_\_\_\_\_ TYPE \_\_\_\_\_ ID# \_\_\_\_\_

Policy Holder name \_\_\_\_\_