The Children’s Museum Wildlife Sanctuary Medical Form

Please mail at least one week prior to class to:

The Children’s Museum, Attn: Wildlife Sanctuary
950 Trout Brook Drive, West Hartford, CT 06119

PLEASE NOTE: We will accept a medical form from your doctor that is current (within 36 months).
HOWEVER, WE ALSO NEED A COPY OF THE FORM BELOW SIGNED BY A PARENT!!

__________________________________________ (child’s name) has no physical or medical conditions that will limit full participation in summer program activities in the Wildlife Sanctuary at The Children’s Museum.

Is he/she allergic to Bee stings or any other allergies?  Yes  No  (circle)

If yes, please describe:____________________________________________________

Is he/she taking any prescription medication?  Yes  No  (circle)

If yes, please list:____________________________________________________

NOTE: Epi-pens MUST come with authorization form from doctor – check with Wildlife Sanctuary office

Does your child have any special needs?________________________________________

If your child has any special needs we request that you discuss with staff prior to first day of class.

Is he/she up-to-date on all the following routine childhood immunizations currently recommended (please check):

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<th>Yes</th>
<th>No</th>
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<th>Yes</th>
<th>No</th>
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<th>Yes</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Measels</td>
<td></td>
<td></td>
<td>Hepatitis B</td>
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<td></td>
<td>Chickenpox</td>
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<td>Mumps</td>
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<td>Diptheria</td>
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<td>Polio</td>
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<td>Rubella</td>
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<td>Pertussis</td>
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<td>Tetanus</td>
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Date of last exam:______________________________

Child’s Physician:________________________________________ Phone:________________________

PERSON TO BE CONTACTED IN CASE OF EMERGENCY (REQUIRED INFORMATION):

________________________________________ Phone:________________________________

In case of a serious medical emergency, The Children’s Museum has my permission to obtain emergency services (911).

Hospital preference:___________________________________________

________________________________________ __________________________

(Signature of Parent or Guardian)  (Date)

Program Attending:________________________________________ Date:________________________