



Youth Medical Health Questionnaire

Child's Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Parent's Name: _____ Home Phone: _____ Work Phone: _____ Cell: _____

Parent's Name: _____ Home Phone: _____ Work Phone: _____ Cell: _____

Employer: _____

Emergency Contact (other than parent): _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Physician's Name: _____ Phone Number: _____

Please list all allergies (i.e. medication, foods): _____

Any known sensitivity to pool chemicals (i.e. chlorine)? _____

Has a physician indicated that your child has a medical condition where they should NOT participate in physical activity? _____

If yes, please explain: _____

Any other reason why your child should NOT participate in our aquatic/fitness programs?

If yes, please explain: _____

Is your child up to date on all immunizations? _____

(PLEASE PROVIDE A COPY OF IMMUNIZATION RECORD)

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Youth Participant Waiver and Release of Liability

I understand this medical health questionnaire serves as a preliminary screening resource to assist wellness center professionals to determine risk to exercise. If the information above indicates an increased risk for participation in aquatic programs, I authorize Mohawk Valley Health System to contact my child's physician for approval and recommendations for the exercise program. If my child or I are at risk and cannot receive medical clearance, I understand that my child or I cannot engage in any exercise tests or receive recommendations from any staff member. I agree that the facility shall not be liable for any injuries or damages arising from the use of the facility. If member is under 18 years of age, this consent **must** be signed by parent/guardian.

Signature: _____ Date: _____

Print Name: _____