BOYS & GIRLS CLUBS
OF MERCER COUNTY

Medical Declaration Statement for Members

Child's Name: _____

Date of Birth: _____ Grade: _____

Is your child under any medical/physical restrictions?

Yes _____ No _____

If yes, check all that apply.

Asthma	_____	Others	_____
Hearing Loss	_____		_____
Diabetes	_____		_____
Seizures	_____		

Is your child taking any medications?

Yes _____ No _____

If yes, please list:

_____

WILL YOUR CHILD BE TAKING ANY MEDICATION(S) REGULARLY WHILE ATTENDING PROGRAM?

Yes _____ No _____

If yes, you need to complete a **CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS** form.

Is your child allergic to any: (Please list.)

Foods?	No	_____	Yes	_____
Medications?	No	_____	Yes	_____
Other?	No	_____	Yes	_____

Family Health Care Provider _____

Telephone Number: _____

As a parent/ guardian of the above participating child, I certify that he/she is in good physical health, has no special medical needs (or I have completed a care form) and may participate in all program activities.

Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY

Monthly Tuition_____ Membership Expires_____

Documents on file: □ Shot Records on file □ 2 pay stubs
□ Child Care Connection □ 21st Century