Participant's Name (last, first) _____ Date_____

Email Address _____

Contact's Email _____

ZACK'S PLACE
HEALTH AND EMERGENCY CARE FORM

General Information

Entering Grade_____ Male ___ Female ___ Age___ Birth Date_____

Custodial Parent's/Guardian's Name: _____

Relationship to Participant: _____ _____

Telephone (day) _____ (evening) _____ _____

Home Address_____

2nd Guardian's Name & Relationship: _____

Telephone (home) _____ (cell) _____ (wk) _____

Home Address_____

Mailing Address_____

Emergency Contacts

If we cannot reach the Parent(s)/Guardian(s) listed above, please provide emergency contacts:

Name	Phone	Relationship
1._____		
2._____		

Pick-Up Authorization

Please list those who are authorized to pick up your participant.

1._____ 2._____

3._____ 4._____

Medical Information

Child's/Ward's Physician _____ Phone _____

Child's/Ward's Dentist _____ Phone _____

Health Insurance Company_____ Policy Number_____

Describe your participant's medical conditions and how they affect his/her ability to participate in certain activities _____

_____

_____

_____

_____

_____

_____

Medications_____

_____

_____

Please provide dates of your participant's most recent immunizations:

Measles_____ Mumps_____ Rubella_____ Polio_____

Date of last tetanus shot: _____ Has he/she had chicken pox? ____yes ____no

Does your participant suffer from any of the following? If so, please provide dates below.

___Ear Infections	___Reaction to Poison Ivy	___Cramps
___Frequent Colds	___Diabetes	___Psychiatric Treatment
___Hypertension	___Severe Sting Reactions	___ADD/ADHD
___Mononucleosis	___Bleeding Disorder	___Heart Disease
___Hay fever	___Food/Other Allergies	___Epilepsy/Seizures
___Penicillin Allergy	___Asthma	___Other (describe below

Comments/Dates:_____

_____

Does your participant need to carry a bee sting kit? ___yes ___no
If so, please be sure he or she knows how to use it and brings it to Zack's Place each day.

Due to the public nature of our site, we cannot guarantee that the area is peanut/nut free.

Special Needs

Describe your participant's special behavioral/physical needs. Please share information about his/her mental, emotional, and physical health that will enable us to better serve him/her, and describe effective strategies for addressing this need.

_____

_____

_____

_____

_____

Parent/Guardian Authorization Statement

In the event that you are unable to reach a parent/guardian or emergency contact by phone while my child is at Zack's Place, I hereby authorize ZP Staff or medical personnel to take emergency measures as needed.

Signature_____Date_____

ZP Release Statement

As a parent of_____ (child's/ward's name), I understand that:

- Although ZP staff will exercise many cautions to prevent mishaps (including adequate adult supervision, extreme care in potentially dangerous situations, clear communication with participants), injuries are still possible. Provided that adequate precautions have been taken by ZP staff, I will assume all risks of injury, hereby releasing and holding harmless Zack's Place, its employees or agents from liability for any such injury.

Parent's/Guardian's Signature_____Date_____

Please submit Health and Emergency Care Form to:
Dail Frates
Executive Director
Zack's Place
P.O. Box 634
73 Central Street
Woodstock, VT 05091
(802) 457-5868