

**HEALTH HISTORY FORM: KALEIDOSCOPE IN ACTION 2010**

**Important: If any information is missing, this form will be returned to you.**

Name of child: \_\_\_\_\_ Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

**Kaleidoscope in Action course codes (Please circle your child’s courses.)**

**28-Golf 51-Dance 55-Jump Rope 75-Hoops 85-Golf 97-Soccer 106-Dance  
130-Yoga 147-Yoga 158-Fun and Fitness**

**Child’s Weight:** \_\_\_\_\_ pounds

**Does this child have any current or past medical issues?** \_\_\_Yes \_\_\_No

If yes, please describe:

**Does this child take any medications at home?** \_\_\_Yes \_\_\_No

If yes, please describe:

**Does this child have any known allergies to foods or medications?** \_\_\_Yes \_\_\_No

If yes, please describe:

**Will this child require any medication at Kaleidoscope this summer?** \_\_\_Yes \_\_\_No

If yes, please describe:

Note: A separate medication authorization form will be required for this purpose. Contact the Kaleidoscope office (978-475-1422) to obtain this paperwork or obtain from website.

**Child’s Doctor’s Name:** \_\_\_\_\_

Doctor’s Address: \_\_\_\_\_

Doctor’s Phone : \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Policy Number: \_\_\_\_\_

**Emergency Contact Information:** In the event that we cannot reach you, please identify at least two emergency contacts (names and phone numbers):

- 1)
- 2)

**Emergency Consent Form:** I, the undersigned, will not hold Kaleidoscope, its agents, servants, or employees responsible for any accidents incurred during participation in the Kaleidoscope program. If my doctor cannot be reached or in case of emergency, consent is hereby given for medical treatment and/or surgical care as recommended by physician or hospital.

\_\_\_\_\_  
**(parent’s signature)**

\_\_\_\_\_  
**(date)**

Please mail this form (prior to May 20) to: Kaleidoscope, Box 506, Andover, MA 01810. You can also fax the form to (978) 475-1422. Thank you.