

YMCA of Greater St. Louis
Child Care Medical Procedures
Chronic Health Conditions

Health Condition: _____

Child's name: _____

Parents names and telephone numbers:

	(Work)		(Home)	
	(Cell)		(Pager)	
	(Work)		(Home)	
	(Cell)		(Pager)	

Physician's name and telephone number:

1. Describe the child's symptoms, including when they generally occur. What triggers an episode?

2. How are mild episodes treated?

3. How are serious episodes treated?

4. Is this child on daily medication, if so is the YMCA to administer any medication?
Give details on administration.

5. Are there any side effects of any medications your child is currently taking - physical and/or behavioral?
If so, please explain.

6. Does physical activity seem to trigger episodes? _____YES _____NO
If so under which conditions should this child not participate in activities?

7. Do weather conditions affect the condition? _____YES _____NO
If so how?

8. Does the child understand their medical and treatment condition? _____YES _____NO
If yes, does the child participate in the management of this condition?

By signing below I acknowledge that I have provided complete and accurate information regarding the health condition of _____ and any and all treatment which the YMCA may need to perform, along with any and all risks associated with the condition or treatment.

Physician/Specialist Signature

Date