



**MEDICAL HISTORY AND IMMUNIZATION RECORD
2025**

**A COPY OF YOUR CHILD'S CURRENT (2025) IMMUNIZATION RECORD FROM EITHER HIS OR HER
ENROLLED SCHOOL OR DOCTOR MUST BE ATTACHED TO THIS FORM**

This form must be completed and signed by the parent /guardian of all children participation in the Wilson Summer Recreation Program

Name of Child: _____

Physician Information: _____ Physician Telephone: _____

Physician Address: _____

Illness and Injury *Please check all boxes that apply:*

Asthma____ Bleeding Clotting____ Diabetes____ Hypertension____

Seizures____ Heart Defect /Disease____ Musculoskeletal Disorders____

Other:

Surguries and or other serious injuries and dates:

Allergies: *Please check all that apply:*

Animals____ Food____ Hay Fever____ Insect Stings____

Medicine____ Pollen____ Sun____ Plants____

Other:

Health Conditions: *Please check of the boxes that apply:*

Emotional Disturbances____ Fainting____ Hearing Impairment____

Wears Glasses / Contacts____ Anxiety____ Depression____

Other:

Please describe if your checked one of the above boxes:

Medications: Please list all medications that your child is taking (prescribed and over the counter)

Medication

Reason

Restrictions

Please indicate any activities that your child is restricted from:

1. _____
2. _____
3. _____

The staff of the Town of Wilson Summer Recreation Program is not trained to administer any medication and are not allowed to apply sunscreen or insect repellent. If your child requires medication (ex. EpiPen, inhalers or repellent), we will have to have a letter from his or her doctor stating that the child is capable of self-administering the medication. If you would like your child to carry and use FDA approved sunscreen, please provide permission.

Check if this applies: Self-medicate _____ Use approved FDA Sunscreen _____

ACCEPTANCE

In consideration of the Town of Wilson accepting my child's application, individually as parent and natural guardian;

I hereby waive, release and forever discharge the Town of Wilson, its employees, agents, representatives, and officers from any and all claims or causes of action for damage which I have or which I may hereinafter have individually or as a parent and natural guardian of my child against the Town of Wilson, its employees, agents, representatives, and officers for any and all damages which may be sustained by me and / or my child in connection with the involvement with the Town of Wilson Recreation Program.

I further agree that any and all medical bills incurred as a result of my child's participation in the Town of Wilson Recreation Program shall be submitted to my health care provider for payment and shall not be the responsibility of the Town of Wilson.

I hereby certify that all of the above information is true and correct.

Parent / Guardian Name (print) _____ Date: _____

Parent / Guardian Name (sign) _____

FOR ADMINISTRATIVE USE ONLY RECEIVED:

Medical Records: Yes / No _____ Date: _____

Release to Self-Medicating Yes / No _____ Date: _____