Youth Program Health Slip

Child's Name_____ _____

Last First Age

Birth Date _____

Parent or Guardian_____
Phone_____

Home Street Address_____ Work
Phone_____

Emergency Contact_____
Phone_____

Is your child allergic to bees? _____ Any food allergies?
_____

Any other allergies or concerns?
_____

____ **I have attached a copy of my child's immunization record as required by the Department on Health to attend the Town of Johnsburg Youth Program.**

____ **I will not send my child to the Youth Pogram if they or any member of their household are sick or show any symptoms of COVID-19.**

In case of an emergency, I give permission to the Johnsburg Youth Program to secure medical treatment for the above child. Every effort will be made to contact the parents or guardian in the event of an emergency.

Signature____________________________________
Date__________________