
Last Name

Amherst Leisure Services
Medical History

A parent/guardian should fill out this form (Front and Back). Please be as thorough as possible.

Participants Name: _____

Age _____ Current Grade _____ School _____ Date of Birth _____

Personal History

Check box beside those medical problems your child has had or currently has. Any other medical information you think may help us please indicate on a separate piece of paper (unless it can fit here).

- | | | |
|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Mild/Severe Ankle Issues |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Mild/Severe Knee Issues |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Seizure Disorder/Epilepsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problem or Murmur | <input type="checkbox"/> Speech Impairment |
| <input type="checkbox"/> Eyesight Impairment | <input type="checkbox"/> Other | |

If any of the below are checked please complete the other side

- | | | |
|-----------------------------------|---|------------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Autism | <input type="checkbox"/> Blindness |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Other |

Allergies: Check and explain reaction/treatment

- | | |
|--|-------|
| <input type="checkbox"/> Medicines | _____ |
| <input type="checkbox"/> Food | _____ |
| <input type="checkbox"/> Animals | _____ |
| <input type="checkbox"/> Insect Stings | _____ |

Is the participant currently taking any medication?

- Yes
 No

If Yes, Please Explain _____

English Language Difficulty 1 2 3 (1 no English, 2 some difficulty, 3 no difficulty)

In case of illness/emergency (when parents/guardians are unable to be reached), please notify:

Name: _____ Home Phone _____ Cell _____

Work _____

I am the legal guardian of _____ and give my permission for him/her to participate in any LSSE activity for which he/she is enrolled. Furthermore, I give LSSE staff permission to administer minor first aid if deemed appropriate. Should more than minor injury occur, requiring emergency treatment, I give permission to the staff to acquire the necessary emergency medical treatment (e.g. ambulance).

I have read and agree with above statement.

Parent/Guardian Signature: _____ Date: _____

Physicians Signature: _____ Date: _____

Form is not complete until signed.

This form will need to be filled out each season by a parent in case of any changes to medical history.

Please Complete other side

Access and Inclusion - Information & Application

Participant Name: _____ Phone: _____
Name of Legal Guardian (if a minor): _____ Participant Age (if a minor): _____
E-Mail Address: _____ Class _____

Please answer each question so that we may create the best access for you/the participant.

1. Does Participant require one-on-one assistance? If you answer yes, please read and sign below.
() Yes* () No

I understand that LSSE and staff are making every effort to fulfill the "reasonable accommodation" request for special needs inclusion into their classes and programs. I also understand that I cannot attend class/program until I have been notified that my request has been successfully arranged.

Legal Guardian Signature

Date

2. Please indicate the nature of participant's "special need" in terms of commonly understood terminology. Is participant labeled as having CAP, Autism, deafness, cerebral palsy, ADHD or other? Please explain.
3. Does participant require physical assistance in any way to better access our programs/classes? For Example-does the participant need assistance holding a brush or making good use of an easel in a painting class? () No () N/A () Yes -please explain
4. Are there any significant communication difficulties of the participant that we should be aware of?
() No () N/A () Yes -please explain
5. Are there behavioral issues for the participant to be accommodated for in our programs/classes?
() No () N/A () Yes -please explain
6. Is there any relevant information that you can provide about participant's learning needs that will help us create a supportive environment in our programs/classes?
() No () N/A () Yes -please explain
7. Would participant benefit from prior contact with the instructor to clarify special learning supports that may not be naturally in place? () No () N/A () Yes -please explain

Permission for LSSE Special Needs Director to access information directly from the participant's education personnel:

- () Yes, I give my permission for LSSE's Special Needs Director, C. A. Ezzell Floraniña, and LSSE program staff, to communicate with the participant's education personnel to better understand their learning style.
- () No, I do not wish for LSSE to communicate with the participant's education personnel.

Legal Guardian Signature

Date

Questions? Contact Ezzell Floraniña at 413-259-3160 or email floranina@amherstma.gov

*In order to accommodate your request for special needs support, we need 3 weeks notice.