



2019/2020

HEALTH ASSESSMENT

13500 Layhill Road, Silver Spring, MD 20906

301-576-2800 fax: 301-576-2805 www.barrie.org

Part I

| TO BE COMPLETED BY PARENT/GUARDIAN   |                           |           |       |
|--|---------------------------|-----------|-------|
| Child's Name (Last, First, Middle)   | Birthdate (Mo., Day, Yr.) | Sex (M/F) | Grade |
| Address (Number, Street, City, State, ZIP)                                 |                           |           |       |
| Parent/Guardian Names  |                           | Phone No. |       |
| Where do you usually take your child for routine medical care?<br>Address: |                           | Phone No. |       |
| When was the last time your child had a physical exam? Month:              |                           | Year:     |       |
| Where do you usually take your child for dental care?<br>Address:          |                           | Phone No. |       |

| ASSESSMENT OF STUDENT HEALTH   |     |    |  |                                |    |
|--|-----|----|--|--------------------------------|----|
| To the best of your knowledge, has your child had any problem with the following? Please check |     |    |  |                                |    |
|  | Yes | No |  | Yes                            | No |
| Anaphylaxis  |     |    |  | Lead Poisoning/Exposure        |    |
| Allergies (Food, Insects, Drugs, Latex)  |     |    |  | Learning Problems/Disabilities |    |
| Allergies (Seasonal)   |     |    |  | Limits on Physical Activity    |    |
| Asthma or Breathing Problems   |     |    |  | Meningitis                     |    |
| Behavior, Emotion, or Mental Problems  |     |    |  | Prematurity                    |    |
| Birth Defects  |     |    |  | Problem with Bladder           |    |
| Bleeding problems  |     |    |  | Problem with Bowels            |    |
| Cerebral Palsy   |     |    |  | Problem with Coughing          |    |
| Dental   |     |    |  | Seizures                       |    |
| Diabetes   |     |    |  | Serious Allergic Reactions     |    |
| Ear Problem or Deafness  |     |    |  | Sickle Cell Disease            |    |
| Eye or Vision Problems   |     |    |  | Speech Problems                |    |
| Head Injury  |     |    |  | Surgery                        |    |
| Heart Problems   |     |    |  | Other                          |    |
| Hospitalization (When, Where, Why)   |     |    |  |                                |    |

If "yes", explain here

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Does your child take any medication?  No  Yes  
 Name(s) of Medication(s): \_\_\_\_\_

Is your child on any special treatments? (nebulizer, Epi-Pen, etc.)  No  Yes  
 Treatment: \_\_\_\_\_

Is your child exempt from immunizations due to parent/guardian objection or medical contraindication?  No  Yes

Waiver of Liability

Although Barrie endeavors to provide a safe environment, I understand that participating in Barrie programs involves a certain amount of unavoidable risk. I agree to release and hold harmless the Barrie School, including officers, directors, employees and agents, from all injuries, damages, claims and causes of action cause by, arising from, or relation to, my child/ward participating in the Barrie Program, as long as such injuries or damages are not the result of gross negligence, intentional neglect, or willful or wanton misconduct by Barrie, its officers, directors, employees and agents.

I further agree to indemnify and defend Barrie, its officers, directors, employees and agents, from all claims, causes of action and damages to person or property caused by, arising from, or in relation to the conduct of my child/ward during his/her participation in a Barrie program or related activities.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

If for religious or other reasons you cannot sign this form, contact the school/camp director for a legal waiver which must be signed for attendance.