## Medical Information

 Does your child have a life-threatening allergy that requires an EpiPen?  
☐ Yes  ☐ No

 If yes, please list your child's allergies.  


 Does your child have asthma that requires use of an inhaler?  
☐ Yes  ☐ No

 Please list any medications your child will take during Youth and Teen Center program hours and the times the medications should be taken. YTC staff does not administer medication. Only medication listed on this form — or, in the case of an illness, on the medication order form — will be permitted in the facility.


 Please list any medications your child takes, regardless of whether they will be taken during YTC program hours.


 Does your child have a history of seizures?  
☐ Yes  ☐ No

 If so, what should YTC staff do if your child has a seizure during our program?


 Does your child have any dietary restrictions?  
☐ Yes  ☐ No

 If so, please explain.


 Does your child have any physical limitations/restrictions?  
☐ Yes  ☐ No

 If yes, please explain.
Does your child have any chronic conditions/illnesses?  □ Yes  □ No
If yes, please explain. ____________________________________________________________

______________________________________________________________________________

Does your child have any cognitive or developmental delays?  □ Yes  □ No
If yes, please explain. ____________________________________________________________

______________________________________________________________________________

**Behavioral Information**

Has your child experienced any emotional trauma?  □ Yes  □ No

______________________________________________________________________________

Does your child have any unusual fears?  □ Yes  □ No
If yes, please explain. ____________________________________________________________

______________________________________________________________________________

Is your child easily upset?  □ Yes  □ No
If yes, what are his/her triggers? __________________________________________________

______________________________________________________________________________

What can be done to calm him/her? ________________________________________________

______________________________________________________________________________

Does your child have difficulty controlling his/her temper?  □ Yes  □ No
If yes, what are your child's triggers? ______________________________________________

______________________________________________________________________________

What can be done to calm your child? ______________________________________________

______________________________________________________________________________

Does your child have any other emotional/behavioral disorders?  □ Yes  □ No
If yes, please explain. ____________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________