



## **Health History and Examination Form (Due May 1, 2019)** Early Reg. Feb 1st

The information on this form is not part of the workshop or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians of minors or by adults themselves. Update required annually. Approved licensed medical personnel must complete health exam at least every two years.

### **Participant Information**

Name \_\_\_\_\_ Last First Middle Birth date \_\_\_\_\_ Age at workshop \_\_\_\_\_

Home address \_\_\_\_\_ Street Address City State Zip

Gender:  Male  Female

Custodial parent/guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home address

(if different from above) Street Address City State Zip

Business address \_\_\_\_\_ Phone \_\_\_\_\_ Street Address City State Zip

Second parent or guardian or emergency contact \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Street Address City State Zip

Business address \_\_\_\_\_ Phone \_\_\_\_\_ Street Address City State Zip

If not available in an emergency, notify \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Street Address City State Zip

### **Insurance Information**

Is the participant covered by family medical/hospital insurance?  Yes  No

If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

**\*Please attach a photocopy of front and back of health insurance card to this form.**

### **Health History**

The parent/ guardian must complete the following information. The intent of this information is to provide workshop health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to workshop health personnel upon participant's arrival at workshop. Provide complete information so that the workshop can be aware of your needs.

**ALLERGIES** List all known. Describe reaction and management of the reaction.

Medication allergies (list)

Food allergies (list)

Other allergies (list) — include insect stings, hay fever, asthma, animal dander, etc.

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**Medications Being Taken**

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at workshop. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

<input type="checkbox"/> This person takes NO medications on a routine basis.	
<input type="checkbox"/> This person takes medications as follows: Med #1 _____ Dosage _____ Specific times taken each day _____ Reason for taking _____	Med #2 _____ Dosage _____ Specific times taken each day _____ Reason for taking _____
Attach additional pages for more medications.	
Identify any medications taken during the school year that participant does/may not take during the summer: _____	

Please select one of the following:

**Bringing No Medication:** My child will not be bringing any medication to workshop.  **Self-Administration:** I would like my child to hold and administer the above medication without workshop supervision.  **workshop Supervised Administration:** I would like workshop staff to hold and supervise the dosage and administration of the above medication. I acknowledge that a person who is not a health professional will provide this service.

**Restrictions**

Explain any restrictions to activity or diet (e.g., what cannot be done or eaten, what adaptations or limitations are necessary)

**General Questions [Explain "yes" answers below.]**

Has/does the participant: Yes No 1. Had any recent injury, illness or infectious disease?..... 2. Have a chronic or recurring illness/condition? ..... 3. Ever been hospitalized? ..... 4. Ever had surgery? ..... 5. Have frequent headaches? ..... 6. Ever had a head injury? ..... 7. Ever been knocked unconscious? ..... 8. Wear glasses, contacts or protective eyewear? ..... 9. Ever had frequent ear infections? ..... 10. Ever passed out during or after exercise? ..... 11. Ever been dizzy during or after exercise? ..... 12. Ever had seizures? ..... 13. Ever had chest pain during or after exercise? ..... 14. Ever had high blood pressure? ..... 15. Ever been diagnosed with a heart murmur? .....	16. Ever had back problems? ..... 17. Ever had problems with joints (e.g., knees, ankles)?..... 18. Have an orthodontic appliance being brought to workshop? ..... 19. Have any skin problems (e.g., itching, rash, acne)? ..... 20. Have diabetes? ..... 21. Have asthma? ..... 22. Had mononucleosis in the past 12 months? ..... 23. Had problems with diarrhea/constipation? ..... 24. Have problems with sleepwalking? ..... 25. If female, have an abnormal menstrual history? ..... 26. Have a history of bed-wetting? ..... 27. Ever had an eating disorder? ..... 28. Ever had emotional difficulties for which professional help was sought? .....
Please explain any "yes" answers, noting the number of the questions (use additional sheet of paper if necessary).	

**Immunizations**

Which of the following has the participant had?

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test  
 Date of last test \_\_\_\_\_  
 Result: 1 Positive 1 Negative

\*\*\* Please give all dates of immunization for:  
 Mo/Yr Mo/Yr

- Vaccine: Dates:
- DTP
- TD (tetanus/diphtheria)
- Tetanus
- Polio
- MMR
- Or Measles
- Or Mumps
- Or Rubella
- Haemophilus influenza B
- Hepatitis B
- Varicella (chicken pox)

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**Parent or Guardian Signature Required; Participant Signature Required.**

This health history is correct and complete as far as I know. The person herein named has permission to engage in all workshop activities except as noted. I hereby give permission to the workshop to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the workshop to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. It is my intention that the workshop be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the workshop be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in workshop activities; and (ii) in the case of minors, to provide relevant information to the workshop representatives to keep me informed of my child's health status. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the workshop to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of workshop.

Signature of parent or guardian \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide by any restrictions placed on my participation in workshop activities.

Signature of participant (workshop) \_\_\_\_\_ Date \_\_\_\_\_

**Health Care Recommendations by Licensed Medical Personnel**

I examined this individual on \_\_\_\_\_. (Exam must be within 24 months of camp attendance. A new exam is not necessarily required for workshop attendance.) BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant  is  is not able to participate in an active workshop program.  
The applicant is under the care of a physician for the following conditions

**Recommendations and Restrictions at Workshop**

Treatment to be continued at workshop \_\_\_\_\_

Medications to be administered at workshop (name, dosage, frequency) \_\_\_\_\_

Known allergies \_\_\_\_\_

Description of any limitation or restriction on workshop activities \_\_\_\_\_

Additional information for health care staff at the workshop \_\_\_\_\_

**\*Signature of Licensed Medical Personnel** \_\_\_\_\_

Printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

\* If participant has recently received a physical and his/her pediatrician has signed a similar form for another school/camp/program, we will accept that form in lieu of getting this form signed.

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