Health History and Examination Form (Due May 1, 2020) 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.

[ ] This person takes NO medications on a routine basis.

[ ] 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?.....	16. Ever had back problems?	
2. Have a chronic or recurring illness/condition?	17. Ever had problems with joints (e.g., knees, ankles)?.....	
3. Ever been hospitalized?	18. Have an orthodontic appliance being brought to workshop?	
4. Ever had surgery?	19. Have any skin problems (e.g., itching, rash, acne)?	
5. Have frequent headaches?	20. Have diabetes?	
6. Ever had a head injury?	21. Have asthma?	
7. Ever been knocked unconscious?	22. Had mononucleosis in the past 12 months?	
8. Wear glasses, contacts or protective eyewear?	23. Had problems with diarrhea/constipation?	
9. Ever had frequent ear infections?	24. Have problems with sleepwalking?	
10. Ever passed out during or after exercise?	25. If female, have an abnormal menstrual history?	
11. Ever been dizzy during or after exercise?	26. Have a history of bed-wetting?	
12. Ever had seizures?	27. Ever had an eating disorder?	
13. Ever had chest pain during or after exercise?	28. Ever had emotional difficulties for which professional help was sought?	
14. Ever had high blood pressure?		
15. Ever been diagnosed with a heart murmur?		

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: l Positive l 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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