

MEDWAY PARKS & RECREATION

HEALTH HISTORY AND EXAMINATION FORM

Health history must be filled out by parents/guardians of minors. Please also submit a copy of the participant's most recent physical exam and immunization record, dated within the past 18 months (update required annually). **These forms must be submitted at least four business days prior to the start of a camp or program.** If forms are not received by the deadline, your child will not be able to participate.

The following information must be filled in by the parent/guardian. The intent of this information is to provide our health care personnel background information to provide appropriate care. Keep a copy of the completed form for your records. If you need to make changes or updates to this form at any time, please contact us.

Name _____ Birth Date _____ Age _____
Last First Middle

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/guardian _____ Phone _____

Home address _____
(If different from above) *Street Address City State Zip*

Business Address _____ Phone _____
Street Address City State Zip

Emergency contact: _____

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 # _____

Family Physician: _____ Phone _____

Address _____
Street Address City State Zip

Family Dentist/Orthodontist: _____ Phone _____

_____ *Street Address City State Zip*

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ALLERGIES List all known and 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.

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Our nurse will handle all medications during each session. Please provide prescription from doctor if taken at camp, as well as a Medication Authorization Form. Please keep medications 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 _____

Med #3 _____ 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:

RESTRICTIONS

The following restrictions apply to this individual.

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

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General Questions Has/does the participant? (Check if "Yes")

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 or concussion?
7. Ever been knocked unconscious?
8. Wear glasses, contacts or protective eye gear?
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 brought to camp?
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. Had emotional difficulties for which professional help was sought?

Please explain any "yes" answers, noting the number of the questions.

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware of.

Please describe your child's swim ability and/or level of last completed Red Cross swim lesson:

Parent/Guardian Authorizations:

This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to provide routine health care by the physician selected by the camp, to secure and administer treatment, including prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for hospitalization, for the person named above. This completed form may be photo- copied for our trips.

In the event I cannot be reached in an emergency, I hereby give my permission for treatment, emergency transportation to health care facility, referral, billing, or insurance purposes.

I give permission to arrange necessary related emergency transportation for me/my child.

Signature of parent/guardian: _____ Printed Name: _____ Date: _____