Christodora-Manice Education Center Summer Program 2009

Health Record, Examination and Medical Release Form

The following information is requested to assist Christodora-Manice Education Center in providing appropriate care for your child. Each child's Health Record and Examination Form is required to be submitted by June 1, 2009, before attending the Manice Education Center. A Physical Examination and a review of the Health History is also required to be completed by an approved licensed medical provider within 24 months prior to participation in a Christodora-Manice Education Center program. We treat all personal medical information with confidentiality. A child's medical information is securely stored and will be shared only with pertinent program staff and medical providers.

Student Name _____ Birth date _____ Age at camp _____
Last First Middle

Home Address _____
Building number Street Apartment City State Zip

Social security number of participant _____ Gender: Male Female (circle one)

Custodial Parent/Guardian _____ Home phone _____ Cell phone _____

Home Address _____
(if different from above) Building number Street Apartment City State Zip

Business Address _____ Work phone _____
Building number Street City State Zip

Second Parent/Guardian _____ Home phone _____ Cell phone _____

Home Address _____
(if different from above) Building number Street Apartment City State Zip

Business Address _____ Work phone _____
Building number Street City State Zip

If parent/guardian not reachable in an emergency notify:

Name _____ Relationship _____ Best number to reach _____

Address _____ Work or Cell phone _____

Insurance Information
Is the participant covered by a work/family/ or individual medical/hospital insurance? Yes No

Insurance Carrier/Plan Name _____ Group/Policy # _____

➔Please attach a copy of the front and back of health insurance card.

Authorization for Participation: section must be read, filled out, and signed by parent or guardian for participant attendance.*

I hereby give permission to the Manice Education Center (MEC) trained staff to administer standard first aid, including over the counter medications unless I listed any restrictions herein. I hereby give permission to the MEC staff to administer all prescription medication I have provided to MEC for my student while at MEC. I hereby give permission to the medical personnel selected by the MEC Director, Assistant Director, Field Teacher or designate to order x-rays or other routine tests and treatment for my student, and in the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the above mentioned to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my student as named above. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to MEC to arrange necessary related transportation for this participant. This completed form will be photo copied for off site trips.

Signature of Parent/Guardian: _____ Date _____

Print name:

Participant agreement:

I understand and agree to abide by restrictions or requirements place on my participation as indicated throughout this form.

Participant Signature _____ Date _____

**If for religious reasons you cannot sign and authorize this form, contact Christodora for a waiver to sign for attendance.*

Health History

The following Health History information must be filled out by the parent/guardian and reviewed by the examining licensed medical provider. Please provide complete information so that the Christodora-Manice Education Center can be aware of your youth participant's entire needs.

	Yes	No		Yes	No
1.Had any recent injury or infectious disease?	☐	☐	15. Have any skin problems?	☐	☐
2. Have chronic recurring illness/condition?	☐	☐	16. Had mononucleosis in past year?	☐	☐
3. Ever been hospitalized?	☐	☐	17. Had serious digestive problems?	☐	☐
4. Ever had surgery?	☐	☐	18. Have problems with sleep walking?	☐	☐
5. Have frequent headaches?	☐	☐	19. Have history of or currently bed wetting?	☐	☐
6. Ever had a serious head injury?	☐	☐	20. Have or had eating disorder?	☐	☐
7. Ever had frequent ear infections?	☐	☐	21. Wear eye glasses or contacts?	☐	☐
8. Ever passed out during exercise?	☐	☐	22. Have orthodontic appliance?	☐	☐
9. Ever had seizures?	☐	☐	23. If female, have an abnormal menstrual history?	☐	☐
10. Ever had chest pain during exercise?	☐	☐			
11. Ever had/have high blood pressure?	☐	☐	24. Have or had emotional difficulties for which professional help was sought?	☐	☐
12. Ever had a diagnosis of heart murmur?	☐	☐			
13. Ever had serious back problems?	☐	☐	25. Have diabetes?	☐	☐
14. Ever had serious joint problems?	☐	☐	26. Have asthma?	☐	☐

Please explain any Yes answers above:

_____

_____

_____

_____

_____

Current Medication Being provided:

☐ This student takes NO medication on a routine basis at this time, and is bringing no medication to camp.

☐ This student takes medication as follows:

Name of Med #1_____ Dosage_____ Frequency _____
Reason for taking: _____

Name of Med #2_____ Dosage_____ Frequency _____
Reason for taking: _____

Name of Med #3_____ Dosage_____ Frequency _____
Reason for taking: _____

Name of Med #4_____ Dosage_____ Frequency _____
Reason for taking: _____

Name of Med #5_____ Dosage_____ Frequency _____
Reason for taking: _____

➔Attach additional pages as needed for more medications.
➔An updated Authorization to Administer Medication Form is due the date of departure.

Our trained staff will administer applicable over the counter medications for first aid treatments and minor aliments, and/or including sunscreen and insect repellant for all participants to the Christodora-Manice Education Center. Please list any over the counter medications your child is allergic to or may not take due to an undesirable medical interaction with their current prescribed medications and the reason why. You are responsible for listing only the over the counter medications your child may not take.

Allergies:

Medication allergies	Medication taken (if any), reaction and management of reaction

Food allergies	Medication taken (if any), reaction and management of reaction

Other environmental /seasonal/ insect	Medication taken (if any), reaction and management of reaction

Restrictions and other considerations:
Dietary: (does not eat, allergic to, special diet because…)

Activity: (due to recent or chronic medical conditions, adaptations, or limitations…)

Please use this space to provide additional information about the participant (physical, mental, emotional, behavior) that you feel the camp should be aware of and may assist in provide safe and beneficial participation in the program.

Immunization History:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP				
TD (tetanus/diphtheria)				
Tetanus				
Polio				
MMR				
Or measles				
Or mumps				
Or Rubella				
Haemophilus influenza B				
Hepatitis B				
Varicella (chicken pox)				
Pneumococcal Conj. (PCV)				
Other				

Which has the participant had or has (dates if available):

Measles	
Chicken pox	
German measles	
Mumps	
Hepatitis A	
Hepatitis B	
Hepatitis C	
Rheumatic Fever	
Seizures	
Diabetes	
Asthma	

Name of family physician _____ phone _____
Address _____
Name of dentist/orthodontic _____ phone _____
Address _____

Medical Examination: to be filled out by an approved licensed medical provider.

I have examined the individual on this date: _____

Height:_____ Weight:_____ Blood pressure:_____

The applicant is under the care of a physician for the following conditions:_____

_____

Treatment to be continued at camp:_____

_____

Description of any limitation or restriction on camp activities:_____

_____

Additional information for health care staff at the camp:_____

_____

_____

➔Attach additional examination results as available.

I have examined the person herein described and reviewed his/her health history.
In my opinion, the above person ☐ is ☐ is not (check one) able to participate in active camp programs.

Signature of Licensed Medical Personnel:_____ Date_____
Printed name: _____ Title_____

Health Care Organization/Clinic name:_____
Address: _____
Phone: _____ Fax:_____