

Summer@Carroll

2010 Staff under age 18 Medical Information and Health History

Complete *both sides* of this form, sign, and return with registration. No child will be admitted without this form completed and signed.

Parents/Guardians are assured the information disclosed will be treated with tact and confidentiality.

Student Name: _____ Date of Birth: _____ M F

Home Address: _____

Parent/Guardian: _____

Home Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Information

Contact 1 Name: _____ Relationship to Student: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Contact 2 Name: _____ Relationship to Student: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Information

Carrier or Plan Name: _____

Subscriber: _____ Group #: _____

Name of Family Physician: _____

Address: _____ Phone: _____

**In addition, please attach a CERTIFICATE OF IMMUNIZATION PROVIDED BY A DOCTOR
IMPORTANT – THIS BOX MUST BE COMPLETED FOR ATTENDANCE**

Parent/Guardian Authorizations: This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to engage in all camp activities except as noted by me and/or the camper's physician. I hereby give permission to Summer@Carroll to provide routine health care, administer prescribed medications, and seek emergency medical treatment. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to Summer@Carroll to arrange necessary related transportation for my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Summer@Carroll to secure and administer treatment, including hospitalization, for the person named above.

Signature of Parent or Guardian: _____

Printed Name: _____ Date: _____

A photocopy of this form shall be as valid as the original

Please turn over and complete back of form.

Allergies (List All Known)

Medical Allergies

Describe Reaction and Management of Reaction

Food Allergies

Other Allergies (include insect stings, hay fever, asthma, animal dander, etc.)

Is an Epinephrine Pen prescribed? YES NO If yes, reason . . . _____

Medications:

- Student takes no medications on a routine basis
- Student takes daily medications:

Please list: _____

If the student takes daily medication, please complete and sign the Authorization to Administer Medication Form.

I consent to have my child receive Tylenol Advil Motrin Benadryl per standing orders
(Initial each medication the nurse may administer.)

Please describe any restrictions to activity (what cannot be done, what adaptations or limitations are necessary):

If the student has experienced any of the following health concerns, please describe the treatment(s) used and the appropriate dates:

Health Concern	Yes	No	Comments-Treatments and Approximate Dates
Cardiac Disorder			
Seizures/Neurological Disorder			
Diabetes/Metabolic Disorder			
Bleeding Disorder			
Hospitalization/Surgery			
Asthma/Respiratory Disorder			
Chronic Illness			
Visual Deficit/Eye Disorder			
Speech Deficit/Throat Disorder			
Diet Restrictions/Digestive Disorder			
Eating disorder			
Orthopedic Disorder			
Chicken Pox			
Mononucleosis			
Psychological concerns			
Headaches			
Head Injury/Concussion			
Menstrual/Genitourinary Disorder			