**Health Form**

**PARTICIPANT INFORMATION**

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Middle Last

Sex\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_\_\_\_\_ Age on arrival at program: \_\_\_\_\_

Month/Day/Year

Date of last Physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Parent/Legal Guardian with legal custody to be contacted in case of illness or injury:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Participant: \_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phones: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list two emergency contacts. Parent/Legal Guardian agrees that the Program has permission to contact the named emergency contacts in the event of an emergency or other appropriate circumstances and consents to the Participant being released to the custody and care of the emergency contact (if deemed necessary or appropriate by the Program) when Parent/Legal Guardian cannot be reached.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact # 1 Name Home Phone Work Phone Cell Phone Relation

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Emergency Contact # 2 Name Home Phone Work Phone Cell Phone Relation

**INSURANCE INFORMATION**

Participant is required to be covered by U.S.-based medical insurance.

Policy Holder’s (P.H.) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ P.H.’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

P.H.’s Relation to Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ P.H.’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Insurance Phone Number: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY**

***Check “Yes” or “No” for each statement. Explain “Yes” answers below.***

Has/does the Participant:

1. Ever been hospitalized?  Yes  No
2. Ever had surgery?  Yes  No
3. Have recurrent/chronic illnesses?  Yes  No
4. Had a recent infectious disease? .......………….......  Yes  No
5. Had a recent injury? ...........................………….......  Yes  No
6. Had asthma/wheezing/shortness of breath?...........  Yes  No
7. Have diabetes? ..................................…………......  Yes  No
8. Had seizures? .........................................................  Yes  No
9. Ever been treated for attention deficit disorder (ADD) or attention

deficit/hyperactivity disorder? ……………………………………  Yes  No

1. Ever been treated for emotional or behavioral difficulties or an

eating disorder? ………………………………………………….  Yes  No

1. During the past 12 months, seen a professional to address

mental/emotional health concerns? ……………………………..  Yes  No

1. Had a significant life event that continues to affect the

Participant’s life? *(I.e. History of abuse, death of a loved one, family*

*change, foster care, new sibling, survived a disaster, others)* …..  Yes  No

1. Had headaches?  Yes  No
2. Wear glasses, contacts, or protective eyewear?  Yes  No
3. Experienced fainting or dizziness?  Yes  No
4. Passed out/had chest pain during exercise?  Yes  No
5. Had mononucleosis (“mono”) during the past 12 months?.  Yes  No
6. If female, have problems with periods/menstruation?.  Yes  No
7. Have problems with falling asleep/sleepwalking?  Yes  No
8. Ever had back/joint problems?…  Yes  No
9. Have a history of bedwetting?…  Yes  No
10. Have problems with diarrhea/constipation?…  Yes  No
11. Have any skin problems?…  Yes  No
12. Traveled outside the country in the past 9 months?.  Yes  No

Please explain “Yes” answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

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The Participant is undergoing treatment at this time for the following conditions:

***(describe below)***  None.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ALLERGIES**

 No known allergies

 To foods *(list)*:

 To medications *(list)*:

 To the environment *(insect stings, hay fever, etc.– list)*:

 Other allergies *(list)*:

 Dietary restrictions *(list)*:

*Describe previous reactions*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Explain/describe if Participant has a need for an EpiPen or Epinephrine*

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**MEDICATION INFORMATION**

 No daily medications.

 Will take the following prescribed medication(s) while at the Program.

Any special storage requirements for the medications are noted below.

Medication Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other treatments/therapies to be continued during the Program**:**

***(describe below)***  None needed.

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**You must attach authorization from a licensed health care provider (ie, a prescription) for all medications Participant will bring to the Program.** All medications must be brought to the Program in their original packaging, and must be checked in with program staff on arrival day to be securely stored. Participants may (and are encouraged to) keep with them urgent-need medications such as inhalers, epinephrine, insulin, and glucagon devices.

**OTC MEDICATION AUTHORIZATION**

The following non-prescription drugs may be stocked by the Program and may be used on an as-needed basis to manage illness and injury. Cross out those this Participant should NOT be given.

|  |  |
| --- | --- |
| Acetaminophen (Tylenol) Ibuprofen (e.g., Advil, Motrin) Guaifenesin Diphenhydramine (e.g., Benadryl) Generic cough drops Lice shampoo or scabies cream Antacids (e.g., Tums)Calamine lotion | Bismuth subsalicylate (e.g., Pepto-Bismol) Laxatives for constipation (e.g., Ex-Lax) Hydrocortisone 1% creamTopical antibiotic creamAloeAntifungal creamLoperamide (e.g., Imodium) |

**OTHER INFORMATION**

Please provide in the space belowany additional information about the Participant’s health that you think important or that may affect the Participant’s ability to fully participate in the program. Attach additional information if needed.

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**IMMUNIZATION HISTORY**

Please provide the following immunization history information. **You must attach a provider record verifying Participant’s immunization history.**

|  |  |
| --- | --- |
| **REQUIRED IMMUNIZATIONS** |  |
|  |
| **Immunization Name** | MM/DD/YYYY | MM/DD/YYYY | MM/DD/YYYY | MM/DD/YYYY |
| **DTaP/DTP/Td** (All Participants must submit documentation of 3 doses of tetanus. One MUST be a Tdap. One must be given in thelast 10 years) |  |  |  |  |
| **Tdap** |  |  |
| **MMR** (Measles, Mumps, Rubella) 2 MMR vaccines required on or after first birthday **OR** positive titers (lab reports must be attache**d)****OR** |  |  |  |
| Measles (single antigen 2 required on or after first birthday) |  |  |
| Mumps (single antigen 2 required on or after first birthday) |  |
| Rubella (single antigen 1 required on or after first birthday) |  |  |
| **Hepatitis B** (The state of NC does not accept titers for this requirement. Designate vaccine type and list dates below.) |
| Engerix-B (3 doses required) OR |  |  |  |  |
| Heplisav-B (2 doses required) |  |  |  |
| **Meningococcal ACWY** (Required after age 12. Booster required after age 16) |  |  |
| **Varicella (chickenpox)**  |  |  |  |
|  Varicella vaccine (2 doses required) OR |  |  |  |
| Varicella IgG positive titer (lab report must be attached) |  |  |  |
| **Polio** (3 doses required for Participants under the age of 18) |  |  |  |  |

**FITNESS TO PARTICIPATE**

I certify that the above information is complete and accurate. I have reviewed and understand the program description and activities of the program and believe that Participant is physically and emotionally fit to participate in the Program without restrictions or adaptations, except as noted below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Yes  No