For Office Use

Year: 2014

Weeks_____

Location:_____

Name:_____

Health History Form for Child Attending Day Program

Based on reporting standards of the American Camp Association and the American Academy of Pediatrics

The information on this form is not part of the student acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to the Program Director upon participant's arrival in the Program. Please provide complete information so that the Program can be fully aware of your child's needs.

Name_____ Birth date_____ Age at Program_____
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_____
Street Address City State Zip

Second parent or guardian or emergency contact_____ Phone_____

Home address_____
(if different from above) Street Address City State Zip

Business address_____
Street Address City State Zip

If not available in an emergency, notify _____ Relationship _____ Phone_____

Home address_____
Street Address City State Zip

IMPORTANT – This box must be complete for attendance*

Parent / Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage is all International Ivy Summer Program (Program) activities except as noted.

I hereby give permission to the Program to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the Program 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 the Program to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of Program premises.

I also understand and agree that my child will abide by any restrictions placed on his/her participation in Program activities.

Signature of parent or guardian_____

Printed name_____ Date_____

** If for religious or other reasons you cannot sign this, contact the Program for a legal waiver which must be signed for attendance.*

ALLERGIES: List all known medication, food, and other allergies. Describe reaction and management of the reaction.

Medication allergies: _____

Food allergies: _____

Other allergies: _____

Please return this form to: International Ivy LLC, 61 Maple Street, #636, Summit, NJ 07901,
Fax: 855-678-6335 Email: info@iisummer.com

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at the Program. 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 student **takes NO medications** on a routine basis OR ☐ This student **takes medication** 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 student does/may not take during summer:_____
_____

RESTRICTIONS (The following restrictions apply to this individual)

Does not eat: ☐ Nuts ☐ Dairy products ☐ Eggs ☐ Other (describe) _____

Explain any restrictions to activity (e.g., what cannot be done, 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?		
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?		
7.	Ever been knocked unconscious?		
8.	Wear glasses, contacts, or protective eyewear?		
9.	Ever had frequent ear infections?		
10.	Ever passed out during 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?		

		Yes	**No**
16.	Ever had back problems?		
17.	Ever had problems with joints (e.g., knees, ankles)?		
18.	Have an orthodontic appliance at Program?		
19.	Have any skin problems (i.e., 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.	Ever had emotional difficulties for which professional help was sought?		

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

Which of the following has the student had?	
	Measles
	Chicken pox
	German measles
	Mumps
	Hepatitis A
	Hepatitis B
	Hepatitis C

Please provide month & year of immunization or attach immunization report from health care provider.

Immunization *(Those noted with * must be current)*	Dose 1 Mo/Yr	Dose 2 Mo/Yr	Dose 3 Mo/Yr	Dose 4 Mo/Yr	Dose 5 Mo/Yr	Most recent dose Month/Year
*Diptheria/tetanus/pertussis (DTaP) or (TdaP)						
*Tetanus booster (dT) or (TdaP)						
*MMR (mumps/measles/rubella)						
*Polio (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test:	Date:	☐ Negative	☐ Positive

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

Name of family physician _____ Phone _____
Address _____
Name of family dentist / orthodontist _____ Phone _____
Insurance Co_____ Member ID # _____

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