

Traveling Players Ensemble Camp Health Form

Performer's Name: _____ Attendance Dates: _____

Address: _____ City/State/Zip: _____

Age at Camp: _____ Date of Birth: _____ (please circle) M / F

Parent/Guardian Name: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Second Parent/Guardian or Emergency Contact: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Alternate Emergency Contact: _____ Relation _____

Home phone: _____ Work phone: _____ Cell phone: _____

Family Physician Name: _____ Phone: _____

Family Dentist/Orthodontist Name: _____ Phone: _____

INSURANCE INFORMATION

Is participant covered by insurance? (Please circle) Y / N If yes, please **attach a photocopy of insurance card**—front and back.

Insurance Carrier: _____ Policy number: _____

ALLERGIES

Describe reaction and management of the reaction

Medication allergies (list all known)

Food allergies (list all known)

Other allergies (list all known, including insect stings, hay fever, asthma, animal dander, etc.)

MEDICATIONS BEING TAKEN- Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely.

This person **takes NO medications** on a routine basis. OR This person **takes medications** as follows

Med #1 _____ Dosage _____ Specific times taken _____

Reason for taking _____

Med #1 _____ Dosage _____ Specific times taken _____

Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year that the participant does/may not take during the summer. _____

RESTRICTIONS (The following restrictions apply to the individual.)

Does not eat: Red meat Pork Dairy Products Poultry Seafood Eggs Other _____

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

Is there any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware? (please circle) Y / N

Use this space to explain _____

GENERAL QUESTIONS (Explain “yes” answers below.)

- | | | | |
|---------------------------------------------------------------|--------|--------------------------------------------------------------|--------|
| Has/does the participant: | Circle | | Circle |
| 1. Had any recent injury, illness or infectious disease?..... | Y / N | 16. Ever had back problems?..... | Y / N |
| 2. Have a chronic or recurring illness/condition?..... | Y / N | 17. Ever had problems with joints (e.g. knees, ankles)?..... | Y / N |
| 3. Ever been hospitalized?..... | Y / N | 18. Have an orthodontic appliance being brought | |
| 4. Ever had surgery?..... | Y / N | to camp?..... | Y / N |
| 5. Have frequent headaches?..... | Y / N | 19. Have any skin problems (e.g. rash, acne)?..... | Y / N |
| 6. Ever had a head injury?..... | Y / N | 20. Have diabetes?..... | Y / N |
| 7. Ever been knocked unconscious?..... | Y / N | 21. Have asthma?..... | Y / N |
| 8. Wear glasses, contacts or protective eye wear?..... | Y / N | 22. Had mononucleosis in the past 12 months?..... | Y / N |
| 9. Ever had frequent ear infections?..... | Y / N | 23. Had problems with diarrhea/constipation?..... | Y / N |
| 10. Ever passed out during or after exercise?..... | Y / N | 24. Have problems with sleepwalking?..... | Y / N |
| 11. Ever been dizzy during or after exercise?..... | Y / N | 25. If female, have abnormal menstrual history?..... | Y / N |
| 12. Ever had seizures?..... | Y / N | 26. Have a history of bed-wetting?..... | Y / N |
| 13. Ever had chest pain during or after exercise?..... | Y / N | 27. Ever had an eating disorder?..... | Y / N |
| 14. Ever had high blood pressure?..... | Y / N | 28. Ever had emotional difficulties for which | |
| 15. Ever been diagnosed with a heart murmur?..... | Y / N | professional help was sought?..... | Y / N |

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

Which has the participant had?	Vaccine:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Measles	DTP	_____	_____	_____	_____
<input type="checkbox"/> Chicken pox	TD (tetanus/diphtheria)	_____	_____	_____	_____
<input type="checkbox"/> German Measles	Tetanus	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Polio	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	MMR	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Measles	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Mumps	_____	_____	_____	_____
	or Rubella	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B	_____	_____	_____	_____
Date of last test _____	Hepatitis B	_____	_____	_____	_____
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (chicken pox)	_____	_____	_____	_____

I understand and acknowledge that my failure to disclose relevant information may result in harm to my child and/or others during an event. I represent and warrant that I have provided all materials and relevant information and that this health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as “personal representatives” for the purpose of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Protection Act of 1996. I hereby agree (pursuant to 45 CFR § 164.51 (b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: for camp representatives to be involved in the person’s health care or payment for care, including: (i) to provide relevant information to the camp representatives related to the person’s ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child’s health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This complete form may be photocopied for trips out of camp.

Signature of **parent/guardian** or **adult camper/staffer** _____

Printed name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation on camp activities.

Signature of **minor** or **adult camper/staff** _____ Date _____

Please attach a photocopy of insurance card—front and back.