CONFIDENTIAL MEDICAL HISTORY AND EMERGENCY FORM

This medical and emergency information form is for your protection. Please examine, complete both sides and sign. No applicant will be allowed to participate in any activities without this form in our files.

Name _____ Nickname _____
Last First Middle initial

Home address _____ Home phone _____
Street City State Zip

Gender: ☐ Female ☐ Male Birth date (mo/day/yr) _____

Height _____ Weight _____ Hair color _____ Eye color _____

IN CASE OF ILLNESS OR INJURY

Person to be notified _____ Relationship _____

Address _____
Street City State Zip

Home phone _____ Work/cell _____

Alternate person _____ Relationship _____

Address _____
Street City State Zip

Home phone _____ Work/cell _____

Physician's name _____ Phone _____

Address _____
Street City State Zip

INSURANCE

La Vida carries limited accident and illness insurance. To keep our costs low we ask participants to carry their own health insurance. Participants may not begin La Vida without proper insurance. **Please include a copy of your insurance card.**

Insurance _____ Policy # _____

Address _____

Subscriber name _____ Subscriber date of birth _____

Occupation _____ Work phone number _____

Consent is hereby given for the applicant to attend a La Vida patrol and, in case of an emergency, permission is given to La Vida and to the physician selected by the program director to hospitalize and secure proper treatment (including x-rays, evacuation, medical, surgical, anesthetics, etc.) which might become necessary.

Signature of participant or parent/guardian (if applicant under age)

_____ Date _____

MEDICAL HISTORY Section I

Applicant name _____

Have you had a history of:

	NO	YES
Epilepsy		
Diabetes		
Hemophilia		
Blood transfusions		
Mental health problems		
Disease of joints		

Please list allergies below

Medication	
Stings, bites	
Foods	
Other	

Have you had any of the following?

	NO	YES	DATE		NO	YES	DATE		NO	YES	DATE
Scarlet Fever				Anxiety/depression				Jaundice			
Measles				Head injury				Hepatitis			
German measles				Recurrent colds/cough				Stomach or intestine trouble			
Mumps				Hay fever, asthma				Headache			
Chicken Pox				Shortness of breath				Dizziness/fainting			
Mononucleosis				Chest pain				Fractures			
Tuberculosis				Gall bladder disease				Sprains/Strains			
Malaria				Gastric/duodenal ulcer				Dislocations			
Eye problems				Diarrhea				Knee injury/trouble			
Ear, nose, throat problems				Hernia				Back injury/trouble			
Appendectomy				Poor appetite				Pneumonia			
Tonsillectomy				Weight gain/loss							
Typhoid fever				Kidney disease/cystitis							
Palpitations				Venereal disease				**FEMALES ONLY**			
High or low blood pressure				Skin - eczema				Breast disease			
Rheumatic fever				Reaction to temperature extremes				Hormone treatment			
Heart murmur								Menstrual disorders			
Weakness/paralysis				Tumor, cancer benign or malignant				Pregnancy or miscarriage			
Insomnia								Vaginal infection			

Health: I would consider myself in ☐ excellent ☐ good ☐ fair ☐ poor health

Fitness: I consider myself in ☐ excellent ☐ good ☐ fair ☐ poor physical condition

Swimming: I can swim ☐ a mile ☐ I can swim ☐ I cannot swim

Exercise: I exercise ☐ daily ☐ regularly ☐ occasionally ☐ seldom

Weight: I am ☐ overweight ☐ underweight ☐ average weight

Any special behavioral problems or habits we should be aware of? _____

_____

SIGN

Signature of participant or parent/guardian (if applicant under age)

_____ Date _____

SIGN

Physician signature (acknowledging review)

_____ Date _____

MEDICAL HISTORY Section II

Applicant name _____

(To be completed by physician)

PHYSICIAN: Please review the information in Section I and complete the questions below. Your signature is required for this to be valid. Incomplete questionnaires will be returned.

Height _____ inches Weight _____ pounds

Blood pressure _____

SYSTEMS REVIEW

Are there any abnormalities of:

	NO	YES	COMMENTS
Head, eyes, ears, nose, throat			
Glands			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic - endocrine			
Neuropsychiatric			
Skin			

Vision: ☐ corrected with glasses _____ ☐ corrected with contact lenses _____

Hearing _____

Is the student now under treatment for any medical or emotional conditions? ☐ Yes ☐ No

Explain _____

Does the student appear emotionally mature? ☐ Yes ☐ No

Explain _____

IMMUNIZATION HISTORY

Immunization histories are not acceptable as evidence of protection for students immunized prior to January 1, 1968.

Measles (MMR) Dates _____	**Mumps** Date _____	**Polio (IPV, OPV)** Date _____		**Whooping cough** Date _____
Rubella (German measles) Date _____	☐ **Tetanus/diphtheria booster** within 10 years Date _____	**Haemophilus influenzae type b (Hib)** Date _____	**Hepatitis B** Date _____	☐ **Varicella vaccine** or ☐ **Chicken Pox** Date _____

Recommendations for physical activity: ☐ Unlimited ☐ Limited

Define activities to be restricted if any _____

How long have you known the student? _____

Present medication? _____ Please send details of treatment schedule.

Photocopy of pertinent hospital and/or investigation records (e.g., EEG, EGG, etc.) ☐ Enclosed ☐ N/A

SIGN

Physician signature _____ Date _____

Print last name _____

Authorization for Administration of Medications at Camp

In order to give prescription medication during camp, parents need to:

- Complete this medication authorization form including a written physician's order/signature authorizing staff to dispense any prescription medication.
- Send medication in the original container with a pharmacy label identifying name, drug, dosage (be specific), time medication should be given and physician's name.
- Note: La Vida staff are NOT authorized to distribute over the counter medications to campers under the age of 18-years-old.

Camper name _____ Patrol dates _____

PHYSICIAN'S ORDER FOR ADMINISTRATION OF MEDICATION: INDIVIDUAL STANDING ORDERS

I have prescribed the following prescription(s) for this camper and request the dosages be given during camp according to instructions listed below:

	DIAGNOSIS	MEDICATION	DOSAGE	FREQUENCY
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Special instructions _____

Physician signature _____ Date _____

Physician's name (print) _____ Phone _____

Address _____

PARENT AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

I hereby give permission for my child to receive medication at La Vida as prescribed by my child's doctor, nurse practitioner or dentist. I authorize reciprocal release of information related to the medication between the camp health director and the prescribing health professional.

Parent signature

_____ Date _____

MAIL THIS FORM OR PHYSICIAN'S ORDER

Before May 16: La Vida, Gordon College | 255 Grapevine Road, Wenham, MA 01984

After May 16: La Vida P.O. Box 219, Lake Clear, NY 12945