



# Health Form

Name \_\_\_\_\_

Male  Female  Birth Date \_\_\_/\_\_\_/\_\_\_ Age on arrival to program \_\_\_\_\_

Is the student covered by family medical insurance  Yes  No

Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Subscriber \_\_\_\_\_

*Please include a copy of your insurance card, front and back so information is readable.*

## General Health History

Has the student:

- |  |  |   |  |
|--|--|---|--|
| Ever been hospitalized? .....          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Had Headaches?.....                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ever had surgery? .....                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Wear glasses or contacts? .....           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have a chronic illnesses?.....         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Had fainting or dizziness? .....          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Had a recent infectious disease? ..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | Passed out during exercise?.....          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Had a recent injury?.....              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Had "mono" during the past 12 months?.... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Had asthma/shortness of breath?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ever had back/joint problems?.....        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have Diabetes?.....                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have problems with diarrhea?.....         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Had Seizures?.....                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have any skin problems?.....              | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If yes for any, please explain:

## Mental, Emotional, Social Health

- Ever been treated for attention deficit disorder or attention deficit/hyperactivity disorder?.....  Yes  No
- Ever been treated for emotional or behavioral difficulties or an eating disorder?.....  Yes  No
- During the past 12 months, seen a professional to address mental/emotional health concerns?.....  Yes  No
- Had a significant life event that continues to affect the camper's life?.....  Yes  No  
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Anything else we should know? *Attach additional information if needed.*

## Authorization for Health Care

**This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.**

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Student \_\_\_\_\_

*Please return all completed documents to MoCo Arts at 76 Railroad St. Keene, NH 03431*

**The following must be completed by a Healthcare Provider**

Physical Exam done today?  Yes  No (If no, date of previous physical \_\_\_\_\_)

Weight: \_\_\_\_\_ lbs.      Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.      Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_

Allergies:

- No Known Allergies
- To foods (list):
- To medications (list):
- To the environment (insect stings, hay fever, etc. list):
- Other allergies (list):

Are Immunizations up to date:  Yes  No    *Please provide a copy of records*

Diet, Nutrition:

- Eats a regular diet.
- Has medically prescribed meal plan or diet restrictions (describe below)

The student is undergoing treatment at this time for the following conditions:     None

Medication:  No daily medications.     Will take the following prescribed medications:

Other treatments/therapies currently undergoing, please describe below:  None

Do you feel the student will require any limitations at camp?  No     Yes (please describe)

**The following medications are commonly stocked; please cross out any that the student should not have. They will be given on an as needed basis.**

Acetaminophen  
Ibuprofen  
Generic Cough Drops  
Calamine Lotion  
Bismuth subsalicylate  
Hydrocortisone 1% cream  
Topical antibiotic cream

**It is in my opinion that the student is physically and emotionally fit to participate in all active programs at MoCo Arts.**

Name of licensed provider (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

*Please return all completed documents to MoCo Arts at 76 Railroad St. Keene, NH 03431*



# Emergency Contact Form

Student Name \_\_\_\_\_

## Emergency Contact 1

Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Relationship to Student \_\_\_\_\_

## Emergency Contact 2

Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Relationship to Student \_\_\_\_\_

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