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

Home address____ Gender: Male Female
Street Address City State Zip

Custodial parent / guardian____ Phone__________________________________

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

Second parent or guardian or emergency contact_________________________________ Phone__________________________

Home Address____
(if different from above) 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: ____

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 # ______________________

LOCATION(S) YOUR CHILD IS REGISTERED FOR ____ **2023**

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

Covi-19 Vax Dates?	

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

Please mail completed health history form by June 1st to International Ivy, 8 Church Street, #71, Liberty Corner, NJ 07938. We do NOT accept this form via mail after June 1st. After June 1st, parents must complete the form online OR bring the form with you on the first day of the Program.