

Name, Program/Session _____
Gender, Birthday _____
Age, Grade _____
Address _____
City, State, Zip _____
Home Phone _____
Parent/Guardian 1 Name _____
P/G 1 Work Phone _____
P/G 2 Cell Phone _____
Parent/Guardian 2 Name _____
P/G 2 Work Phone _____
P/G 2 Cell Phone _____

MERROWVISTA 2010
HEALTH HISTORY FORM
To be completed by Parent/Guardian

Please answer all questions thoroughly. This information is important for the participant's safety. You should know that over the years, many participants with a variety of medical / psychological difficulties have successfully completed our programs, but we must be aware of these conditions. Please provide all information which will ensure the participant receives quality care.

Please verify information above.

Insurance Information

AYF must receive a copy of subject's insurance card. Any co-pays or medical treatment not covered by his/her policy will be billed to the family. **If uninsured or without a copy of the insurance card, all medical expenses will be the responsibility of the family.

Insurance Company: _____ Phone Number: _____

Employer: _____ Policy Number: _____

Employee (carrier): _____ Group Number: _____

Permission to Treat

***Health History Form is not valid without applicable signatures below.**

I give permission to the AYF/Merrowvista and their staff or designated personnel to treat the above mentioned participant for routine medical procedures, including the dispensing of over the counter medications and to treat the participant in the case of emergency situations or hospitalizations including surgical procedures. I have completely answered all of the questions on this form and have provided complete medical information relevant to the proper care and treatment of the participant. I understand the omission of information can jeopardize the participant's health and overall program experience. I give permission to the Health Center Staff to share the minimum necessary information related to the physical and mental health of the above participant with appropriate AYF/Merrowvista staff, and if necessary with medical providers and/or emergency personnel, as she/he determines is necessary for participants health and safety. I expect that information shared will be respected as confidential by AYF/Merrowvista personnel.

Signature of Parent or Legal Guardian _____ Date _____

Please complete and mail all forms no later than April 10th, 2010 to:
Camp Merrowvista, Registrar, 147 Canaan Rd, Ctr Tuftonboro NH 03816

Has the participant experienced any of the following? If so, please provide a checkmark.

Please consider current and past conditions. If you check any of the items below, please reference the number and explain on page 4.

Allergies:

Allergy to Bee Stings? _____

Allergy to Medications? _____

Epi-pen required? Yes No

Other Allergic Reactions (food, foreign proteins, etc.)?

If yes, explain _____

Has the participant experiences any of the following? If so, please provide a checkmark.

Please consider current and past conditions. If you check any of the items below, please reference the number and explain on page 4.

1 Arthritis.....	_____	15 Diarrhea.....	_____	29 Kidney Problems.....	_____
2 Asthma.....	_____	16 Digestive Disorders.....	_____	30 Learning Disability	_____
3 Back Condition.....	_____	17 Dizziness associated w/exercise	_____	31 Lung Disease.....	_____
4 Balance Problems.....	_____	18 Ear Infections.....	_____	32 Menstrual Abnormalities	_____
5 Bed Wetting.....	_____	19 Epilepsy.....	_____	33 Nightmares.....	_____
6 Blood Disorder.....	_____	20 Fainting Spells.....	_____	34 Rheumatic Fever.....	_____
7 Bowel/Bladder Control Problems	_____	21 Frequent Colds and Sore Throat	_____	35 Seizures.....	_____
8 Broken Bones.....	_____	22 Head Injury/Concussions.....	_____	36 Skin Problems.....	_____
9 Bronchitis.....	_____	23 Headaches/ Migraines.....	_____	37 Sleep Talking.....	_____
10 Chicken Pox.....	_____	24 Heart Disease/Irregularity.....	_____	38 Sleep Walking.....	_____
11 Circulation Problems.....	_____	25 Heat Stroke.....	_____	39 Stomach Upsets/Ulcers..	_____
12 Constipation.....	_____	26 Hemophilia.....	_____	40 Strokes.....	_____
13 Development Disability.....	_____	27 Hypertension.....	_____	41 Surgeries.....	_____
14 Diabetes.....	_____	28 Hypo/Hyperglycemia.....	_____	42 Other: _____	_____

	Has/does the participant:	YES	NO	If you checked yes, please explain below:
43	Been treated or hospitalized in past 24 months?	<input type="checkbox"/>	<input type="checkbox"/>	
44	Have any chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	
45	Have any mobility impairment?	<input type="checkbox"/>	<input type="checkbox"/>	
46	Have any sensory, physical or cognitive disabilities?	<input type="checkbox"/>	<input type="checkbox"/>	
47	Have any dietary restrictions?	<input type="checkbox"/>	<input type="checkbox"/>	
48	Wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	
49	Have a medical or dental appliance?	<input type="checkbox"/>	<input type="checkbox"/>	
50	Currently or recently used tobacco, drugs, alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	

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Name _____
 Program/Session _____
 City, State _____

If you have answered **YES** to any of the items, please explain below. Include the following information:

- Specific symptoms that are occurring? • How long symptom / condition lasts? • Date of last occurrence?
- How often symptoms / condition occurs? • How you care for symptom / condition?
- How symptom / condition affects your activity in any way, including ability to run, lift, and climb?

Immunization Status

For All Participants:

Are immunizations up to date? Yes No Date of last Tetanus Booster: _____

Does participant currently have any infectious diseases? Yes No If yes, explain: _____

New Participants Only: Please attach a copy of the participant's immunization record.

All Medications

Please list **all** current medications:

Medication Name	Dosage	Times	Start Date	Purpose	Special Instructions / Current Side Effects

Please Note: If participant has an allergy requiring an epi-pen, and/or asthma requiring an inhaler, he/she must bring **2 epi-pens and/or 2 inhalers**. One can be carried on participant's person at all times and one will remain in the Health Center as back up. All medications are to be turned over to the Health Center staff at registration and must be in their original containers. This includes prescriptions and over the counter medications required by the participant. Please send appropriate amounts of medication for the amount of time your child is at camp. Please do not bring aspirin, Tylenol, Advil, Sudafed, Benadryl, etc. to camp, as these are available in the Health Center as needed.

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