



American Youth Foundation
 Merrowvista
 147 Canaan Road, Ctr. Tuftonboro, NH 03816
 603-539-6607 • 603-539-7504 (fax)
 www.ayf.com

MERROWVISTA 2012

HEALTH HISTORY FORM

To be completed by Parent/Guardian

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 _____

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 _____

Important Information Regarding Physical Examinations and the Health Memorandum Form

All campers must have had a physical examination within 24 months of the camp session. The Health Memorandum Form must be completed and submitted for the camper each year. Though it must be completed by a physician, it does not require a camper to receive a physical examination as long as the camper's last physical exam took place after July 1, 2010. It can be completed with information gathered in the last physical and must be signed by the physician.



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 allergy or dietary need and explain on page 4.**

Allergies:

Allergy to Bee Stings? _____

Allergy to Medications? _____

Epi-pen required? Yes ___ No ___

If yes, has the camper ever needed to use the epi-pen? Yes ___ No ___

Does your child have special dietary needs or food allergies? Yes ___ No ___

No meat ___ No dairy ___ No Peanuts ___ No Wheat/Gluten ___ No Tree Nuts ___ Other _____

| | | |
|---|---|---|
| 1 Arthritis..... Yes ___ No ___ | 15 Diarrhea..... Yes ___ No ___ | 29 Kidney Problems..... Yes ___ No ___ |
| 2 Asthma..... Yes ___ No ___ | 16 Digestive Disorders..... Yes ___ No ___ | 30 Learning Disability Yes ___ No ___ |
| 3 Back Condition..... Yes ___ No ___ | 17 Dizziness associated w/exercise Yes ___ No ___ | 31 Lung Disease..... Yes ___ No ___ |
| 4 Balance Problems..... Yes ___ No ___ | 18 Ear Infections..... Yes ___ No ___ | 32 Menstrual Abnormalities Yes ___ No ___ |
| 5 Bed Wetting..... Yes ___ No ___ | 19 Epilepsy..... Yes ___ No ___ | 33 Nightmares..... Yes ___ No ___ |
| 6 Blood Disorder..... Yes ___ No ___ | 20 Fainting Spells..... Yes ___ No ___ | 34 Rheumatic Fever..... Yes ___ No ___ |
| 7 Bowel/Bladder Control Problems Yes ___ No ___ | 21 Frequent Colds and Sore Throat Yes ___ No ___ | 35 Seizures..... Yes ___ No ___ |
| 8 Broken Bones..... Yes ___ No ___ | 22 Head Injury/Concussions..... Yes ___ No ___ | 36 Skin Problems..... Yes ___ No ___ |
| 9 Bronchitis..... Yes ___ No ___ | 23 Headaches/ Migraines..... Yes ___ No ___ | 37 Sleep Talking..... Yes ___ No ___ |
| 10 Chicken Pox..... Yes ___ No ___ | 24 Heart Disease/Irregularity..... Yes ___ No ___ | 38 Sleep Walking..... Yes ___ No ___ |
| 11 Circulation Problems..... Yes ___ No ___ | 25 Heat Stroke..... Yes ___ No ___ | 39 Stomach Upsets/Ulcers.. Yes ___ No ___ |
| 12 Constipation..... Yes ___ No ___ | 26 Hemophilia..... Yes ___ No ___ | 40 Strokes..... Yes ___ No ___ |
| 13 Development Disability..... Yes ___ No ___ | 27 Hypertension..... Yes ___ No ___ | 41 Surgeries..... Yes ___ No ___ |
| 14 Diabetes..... Yes ___ No ___ | 28 Hypo/Hyperglycemia..... Yes ___ No ___ | 42 Other: _____ Yes ___ No ___ |

| | Has/does the participant: | YES | NO | If you checked yes, please explain below (additional space on page 3) |
|----|--|-----|----|--|
| 43 | Been treated or hospitalized in past 24 months? | | | |
| 44 | Have any chronic illness? | | | |
| 45 | Have any mobility impairment? | | | |
| 46 | Have any sensory, physical, or cognitive disabilities? | | | |
| 47 | Have any dietary restrictions? | | | |
| 48 | Wear glasses or contact lenses? | | | |
| 49 | Have a medical or dental appliance? | | | |
| 50 | Currently or recently used tobacco, drugs, alcohol? | | | |

**Please complete and mail all forms no later than April 15th, 2012 to:
Camp Merrowvista, Registrar, 147 Canaan Rd, Ctr Tuftonboro NH 03816**

Name _____

Program/Session _____

City, State _____

If you checked or answered **YES** to any of the items on page 2, please explain below. Include the following information:

- Specific symptoms that are occurring?
- How long symptoms / condition lasts?
- Date of last occurrence?
- How symptoms / condition affects activity in any way, including ability to run, lift, and climb?

IMMUNIZATION STATUS

Please attach a copy of immunization record if camper is new, or if a returning camper has received updates.

Does participant currently have any infectious diseases? Yes____ No ____

If yes, explain: _____

Date of last Tetanus Toxoid Immunization (mm/yyyy): _____

MEDICATIONS

Daily medication information must be submitted to CampRx 30 days prior to camp opening.

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 inhaler can be carried at all times and one will remain in the Health Center as back up.

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