

Program name _____ Program dates _____

Princeton-Blairstown Center
158 Millbrook Road Blairstown, NJ 07825
(908) 362-6765 Fax (908) 362-7699

Health Information Form

Participant name _____ M F Birth date _____ Age _____

Address _____
Street City State Zip

Custodial parent/guardian _____ E-mail _____

Home phone _____ Cell _____ Business _____

Second parent/guardian _____ E-mail _____

Home phone _____ Cell _____ Business _____

If parents/guardian not available in an emergency, notify _____

Relationship _____ Home phone _____ Business/cell _____

Insurance information Is the participant covered by family medical insurance? Yes No

If so, indicate plan name _____

Group/Policy # _____ Subscriber ID _____

Photocopy of front and back of health insurance card must be attached to this form.

Both boxes must be signed in order for participant to attend.

This health history is correct and I've completed all questions, sections, and pages as far as I know.
The participant named has permission to engage in all the center activities except as noted.

I give permission to the medical personnel selected by the center to provide routine health care, administration of prescribed medications, and the following over-the-counter medications: Benadryl (or similar); hydrocortisone cream; triple antibiotic ointment; Pepto-Bismol (or similar); Tylenol (or similar); and Motrin (or similar). I also give permission for the administration of epinephrine in the event of a severe allergic reaction or asthma attack. Circle any medications you do NOT authorize the staff to administer.

In the event I cannot be reached in an emergency, I give permission for the physician selected by the center to secure and administer treatment, including hospitalization, for the participant.

I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. This completed form may be photocopied for trips out of the center.

The participant may be released to the person designated as an emergency contact.

Signature of parent/guardian or adult participant _____ **Date** _____

I understand and agree to comply with any restrictions placed on my participation in the center activities.

Signature of youth or adult participant _____

Participant Name: _____

Health History

ALLERGIES (List all known)
To Medication

Describe reaction and management of reaction
(Do any meds need to be refrigerated)

To Food

To Other

(Include iodine, shellfish, insect stings, pollen, etc.)

RESTRICTIONS

Dietary (describe)

Activity (what cannot be done, what adaptations or limitations are necessary)

MEDICATIONS BEING TAKEN

Please list ALL medications taken routinely (including over-the-counter or herbal remedies). Bring enough medication to last the entire time at the Center. Keep medicine in the original packaging or bottle that identifies the prescribing doctor (if a prescription drug), the name of the medication, the dosage, and how often the medication is to be given.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Please attach additional pages for more medications.

Identify any medication taken during the school year that participant does not take during the summer.

Participant Name: _____

General Questions (Explain "yes" answers below)

Has/does the participant:

	Check for "Yes"		Check for "Yes"
1. Had any recent injury or illness?		11. Have asthma?	
2. Ever been hospitalized or had surgery?		12. Have a chronic/ recurring illness?	
3. Ever had an eating disorder?		13. Have an orthodontic appliance (e.g. retainer) being brought to the center?	
4. Ever been diagnosed with Attention Deficit Hyperactivity Disorder?		14. Have any skin problems (e.g. eczema, acne)?	
5. Ever had emotional difficulties for which professional help was sought?		15. Have problems with diarrhea or constipation?	
6. Ever had a head injury or seizures?		16. Have problems with sleepwalking or bedwetting?	
7. Ever had back or joint problems?		17. If female, have an abnormal menstrual history?	
8. Ever been dizzy or passed out during or after exercise?		18. Have diabetes?	
9. Ever had chest pain during or after exercise?		19. Have frequent headaches?	
10. Ever been diagnosed with a heart murmur?		20. Wear glasses or contacts?	

Please explain any "yes" answers

Name of participant's doctor _____ Phone _____
Address _____
Name of participant's dentist/orthodontist _____ Phone _____
Address _____

Please use this space to provide any additional information about the participant's behavior or physical, emotional, or mental health about which Princeton-Blairstown Center should be aware.

Examination by Licensed Medical Personnel

Patients Name _____

I examined this individual on Date _____. Height _____ Weight _____ BP _____

Princeton-Blairstown Center activities include canoeing, biking, hiking with a 40 lb. backpack, climbing, and swimming. In my opinion, the above applicant (is) (is not) able to participate in an active the center program.

The applicant is under the care of a physician for the following conditions: _____

Recommendations and Restrictions while at the Center

Treatment to be continued at the center

Medications to be administered at the center (name, dosage, frequency)

Any medically prescribed meal plan or dietary restrictions _____

Known allergies _____

Description of any limitation or restriction on the center activities

Additional information for the health care staff at the center

***Please attach a copy of the participant's immunization record.
Tetanus/Diphtheria immunization should be within the past 10 years.***

Signature of Licensed Medical Personnel _____

Printed name _____ Title _____

Address _____ Date _____

Phone _____ Fax _____

FOR THE CENTER USE ONLY

Date and initials of health information form screener _____

Date and initials of participant screener _____

Medications received _____

Other _____