Dear NEMC Parent:

It is our privilege to care for your child while they are at camp. In order to do so safely and effectively, we ask that you use the checklist below to assure that all important information and signatures are obtained prior to returning this form to camp no later than June 1st. Thank you.

Sincerely,
NEMC Nursing Staff

- ◻ Camper Health History form must be on file prior to arrival at NEMC
- ◻ Insurance information complete (photocopy both sides of your insurance card and attach to Health History form)
- ◻ Parent/Guardian signature for "permission to treat" with a witnessed signature (bottom of page 1)
- ◻ Please list all allergies and treatments
- ◻ Please list all medications (even over the counter medications) taken regularly
- ◻ Completed physical form by medical provider within last 12 months
- ◻ Copy of immunization records

New England Music Camp
8 Goldenrod Lane
Sidney, ME 04330

Health History and Examination Form

The information on this form is not part of the camper acceptance process, but it is gathered to assist in identifying appropriate care. This form, except for the "Health Recommendations of Licensed Healthcare Provider," is to be completed by the parents/guardians and camper. **Please mail it to NEMC by June 1st.**

Camper's Name ______________________________
Last First Middle

Home address ______________________________
Street address

____
City State Zip Code

❑ Male

❑ Female

Registered for :
❑ 1st session
❑ 2nd session
❑ Full Session (6 weeks)

Birth date ________________ Age at Camp _____

Custodial parent/ guardian ______________________________

Home address ______________________________

____

Home Phone ________________________

Business Address ______________________________

____

Business phone ____________________________

Cell phone ________________________________

Second parent/ guardian emergency contact ______________________________

Home address ______________________________

____

Home Phone ___________________________

Business Address ______________________________

____

Business phone ________________________________

Cell phone ____________________________________

If not available in an emergency, notify:

Name ______________________________ Relationship__________________________ Phone Number _________________________

Street, City, State, Zip code ______________________________

Please note that the following boxes must be completed for attendance at camp. Attach photocopies of medical/hospital insurance coverage and prescription plan, if separate. FRONT and BACK of cards.

Insurance information
Is the participant covered by family medical/hospital insurance? ❑ Yes ❑ No
If so, indicate the name of the carrier or plan name ______________________________ Group number ______________________

Carrier address (street, city, state, zip code) ______________________________

Name of insured ______________________________ Relationship to participant______________________________

Social Security Number of the policy holder or insurance I.D. number ______________________________
Does the above insurance cover prescription medications? ❑ yes ❑ no
If no, how do you normally pay for these medications?
❑ prescription plan name ______________________________ Person insured ______________________________ ID/policy number ________________
❑ out of pocket

Permission to provide necessary treatment or emergency care:
I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests or treatment; to release any records necessary for insurance purposes; and to provide or arrange related transportation for me or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips outside of camp.

Signature of parent/
Guardian witness Date

I also understand and agree to abide by the restrictions placed on my camp activities.
Signature of minor camper ______________________________ Date ___________________

If for religious reasons, you cannot sign this, contact the camp for a legal waiver that must be signed for attendance.

Camper Name ________________________________ **Date of Birth** ______________

Health History

The following information must be filled in by the parent/guardian/camper. It will give camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records and notify the camp health personnel of any changes when the participant arrives at camp. Give complete information so the camp can be aware of your needs.

Allergies (list all known) Describe reaction and management of reaction

Medication allergies (list)

____________________ ____

____________________ ____

Food allergies (list)

____________________ ____

____________________ ____

Other allergies (list- include bee stings, hay fever, animal dander, etc)

____________________ ____

____________________ ____

Medications being taken:

Please list all medications (including over-the-counter or nor-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original container that identifies the name of the medication, dosage, frequency of administration and prescribing physician. Some generic over-the-counter medications are provided at camp. You may also send preferred over-the-counter medications.

❑ This person takes no medications on a routine basis.

❑ This person takes medications as follows:

Medication #1 ______________________ Dosage ________ ❑ as needed ❑ daily (please note times) ____________
Reason for taking ____

Medication #2 ______________________ Dosage ________ ❑ as needed ❑ daily (please note times) ____________
Reason for taking ____

Medication #3 ______________________ Dosage ________ ❑ as needed ❑ daily (please note times) ____________
Reason for taking ____

Medication #4 ______________________ Dosage ________ ❑ as needed ❑ daily (please note times) ____________
Reason for taking ____

Medication #5 ______________________ Dosage ________ ❑ as needed ❑ daily (please note times) ____________
Reason for taking ____

Identify and medications taken during the school year that the participant does/may not take in the summer ______________________
____

Please attach pages to submit additional information. Approved by ________________________________
Signature of parent

Please check the over-the-counter medications you want your child to receive to relieve pain or other discomforts. (If your child takes any of these or other over the counter medications on a daily basis you are responsible for bringing an appropriate personal supply to camp.)

- ❑ Acetaminophen (Tylenol)
- ❑ Loratadine (Claritin)
- ❑ Meclizine (Bonine)
- ❑ Visine
- ❑ Ibuprofen (Advil)
- ❑ Diphenhydramine HCL (Benadryl)
- ❑ Clotrimazole (Lotrimin)
- ❑ Mometesone (Elocon)
- ❑ Orajel

Camper Name ______________________________________ Date of Birth _______________

General History: Check "True" or "False" for each statement

		True	False
1.	This camper has had chicken pox or has received the varicella immunization………	❑	❑
2.	This camper has NOT had mononucleosis ("mono") during the past school year………	❑	❑
3.	This camper's hearing is within normal ranges………	❑	❑
4.	This camper's sight is within normal ranges or uses corrective lens to remedy vision………	❑	❑
5.	This camper typically sleeps without snoring, sleep talking or making disruptive noises………	❑	❑
6.	This camper is prepared to fall asleep at night without supports such as reading or listening to music………	❑	❑
7.	This camper is free of illness, injury or physical challenge that would affect program participation………	❑	❑
8.	For girls: this camper knows about menstruation and/or has a normal menstrual history………	❑	❑
9.	This camper has history of head injury………	❑	❑
	Explain:____		
10.	This camper has been in countries outside the United States in the past nine months………	❑	❑

If "True" list the countries and the length of time spent:

Country :__________________________________Dates:__________________________________

Country :__________________________________Dates:__________________________________

11. Camper's Physician:______________________________ Office Phone:______________________________

12. Camper's Orthodontist______________________________ Office Phone:______________________________

Mental, Emotional and Social Health: Check "Yes or "No"

	Yes	No
1. This camper has been diagnosed with Attention Deficit Disorder (ADD or AD/HD)………	❑	❑
2. This camper has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder, bipolar disorder………	❑	❑
3. This camper has an emotional health concern (Specifically:______________________) ………	❑	❑
4. During the past academic year this camper has seen or is currently seeing a professional to address mental/emotional concerns…	❑	❑

If "yes" was the answer to any of the four statements above, attach a statement from your child's professional (e.g., psychiatrist, physician) that addresses the following three things:

a. Describes the concern and the camper's management plan (including medications) while at camp
b. Describes the behaviors that will indicate to our staff that your camper needs professional referral; and
c. Provides a recommendation from this professional supporting your child's participation in our camp program.

5. This camper has had a significant life event that continues to affect the camper's life……… ❑ ❑
If "Yes", please provide written information about the event – death of a loved one, family change, adoption, new sibling, survived a disaster – its impact upon your child's life, and care tips for your child's cabin counselors.

Chronic Health Concerns: Check those that pertain to this camper and describe how you handle this at home.
❑ This camper has no chronic health concerns and is capable of full participation in the cam program.
❑ This camper has the following chronic health concern(s):

❑ Asthma	❑ Headaches	❑ Sleepwalking	❑ Diabetes	❑ Cardiac Condition
❑ Bedwetting	❑ Menstrual Cramps	❑ Frequent Ear Infections	❑ Fainting	❑ Other (describe below)
❑ Encopresis	❑ Seizure Disorder	❑ Frequent Colds	❑ Surgical History of Consequence	

Information about items above (attached if needed)____

Provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware

____

____

Activity and dietary restrictions: ____

Name of additional health service providers currently giving care______________________ phone:______________________

Service provided:____

Parent/Guardian Authorization: The health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted:

Signed: Printed: Date:

Camper Name ________________________________ **Date of Birth** ________________

Healthcare recommendations by licensed healthcare provider for ____________________________
Name of camper

This examination report page is to be completed and signed by the participant's primary care provider. It must be based on an exam completed during the school year prior to the beginning of camp.

Date of exam ____________________

Blood pressure __________ Weight _________ Height _________

In my opinion, the applicant ❑ is ❑ is not able to participate in an active camp program.

The application is under the care of a physician for the following condition(s) ____

____
____
____
____

Active treatment at the time of this report includes ____

____
____
____
____

Recommendations and restrictions for camp program

Treatment to be continued at camp ____
____
____

Medications to be administered at camp (name, dosage, frequency) ____
____
____

Any medically-prescribed meal plan or dietary restrictions ____
____
____

Known allergies ____
____
____

(Note: Allergy desensitization treatments will only be permitted with a doctor’s written order)

Description of any limitations or restrictions of camp activities ____
____
____

Additional information for the camp health care staff ____
____
____
____

- **Please include a copy of immunization record with this form**

Signature of licensed healthcare provider ________________________________ Date ________________

Printed Name ________________________________ Phone ________________

Address ____
Street address City State Zip Code