

HEALTH STATEMENT

Kids' Bay Adventure Education Program at Horn Point

PARENT/GUARDIAN COMPLETE PAGE 1

FAMILY INFORMATION

Student Name _____ Birth Date ____/____/____ Male ___ Female ___

| | |
|---|---|
| <p>Parent (Father)/Guardian(s): Full Name _____</p> <p>Home Address _____</p> <p>City _____ State _____</p> <p>Zip _____ Home Phone _____</p> <p>Work Phone _____ Cell Phone _____</p> <p>E-Mail Address _____</p> | <p>Parent (Mother)/Guardian(s): Full Name _____</p> <p>Home Address _____</p> <p>City _____ State _____</p> <p>Zip _____ Home Phone _____</p> <p>Work Phone _____ Cell Phone _____</p> <p>E-Mail Address _____</p> |
|---|---|

Emergency Contacts: *Please note that every attempt will be made to contact you in the event of an unexpected illness or injury. If we are unable to reach you, we will contact the persons listed below:*

| | |
|------------------|--------------------|
| 1. Name _____ | Home Phone _____ |
| Work Phone _____ | Relationship _____ |
| 2. Name _____ | Home Phone _____ |
| Work Phone _____ | Relationship _____ |

Confidential Consent for Medical Treatment

If your child is under the age of 18, it is our policy to secure your consent for medical treatment.

I understand that in case of an emergency, every effort will be made to contact a parent or guardian prior to treatment. If a parent or guardian cannot be reached, however, and the situation requires immediate medical attention as determined by staff, I hereby authorize representatives of the University of Maryland Center for Environmental Science (UMCES) Horn Point Laboratory to transport my child to the nearest hospital. UMCES Horn Point Laboratory, its officers, board members, leaders, employees and agents will not be held liable for procedures performed pursuant to this consent. Photocopies of this form may serve the purpose of the original for the purpose of going off campus.

Signature of Parent or Legal Guardian

Date

Insurance Information

| | |
|---|---------------------|
| Name of Insurance Company _____ | Phone # _____ |
| Name of Policy Holder _____ | Policy Number _____ |
| Name of Personal Physician _____ | Phone # _____ |
| Name of Dentist _____ | Phone # _____ |

Kids' Bay Adventure Education Program at Horn Point

PHYSICIAN COMPLETE PAGES 2 & 3

All students are required to have required immunizations up to date before attending this program.

To the Physician: Please review this child's history and complete this form. Please place a check mark where applicable. The information supplied will not affect his/her admission into the program, but will provide staff with background information for providing care. This information is strictly confidential and will not be released without parent/guardian consent.

Student Name _____

Date of last comprehensive exam _____

Check all that apply that are current or recurring.

| | | |
|--|--|---|
| Health History | | |
| <input type="checkbox"/> ADD | <input type="checkbox"/> Emotional Upsets | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Lack of Coordination |
| <input type="checkbox"/> Bleeding/ Clotting Disorder | <input type="checkbox"/> Frequent Sore Throat | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Frequent Earaches/ Infections | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Stomach Upsets |
| | | <input type="checkbox"/> Other |
| Please describe conditions and give dates: _____ | | |
| _____ | | |
| Comment where applicable: (For Overnight Programs Only) <input type="checkbox"/> Bed Wetting <input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Sleep Walking <input type="checkbox"/> Homesickness | Limitations Activity Restrictions _____ _____ Diet Restrictions _____ _____ | |
| Other: _____ | | |

| | |
|--|---|
| Allergies | |
| <input type="checkbox"/> Animals _____ | <input type="checkbox"/> Medicine/Drugs _____ |
| <input type="checkbox"/> Food _____ | <input type="checkbox"/> Plants _____ |
| <input type="checkbox"/> Hay Fever _____ | <input type="checkbox"/> Pollen _____ |
| <input type="checkbox"/> Insect _____ | <input type="checkbox"/> Other _____ |
| Does your child require immediate medical attention? _____ | |
| Does your child require an EPIPEN? _____ | |
| Any other comments? _____ | |

OVER

Medications

List all **medications** the student is currently taking (prescription and over-the-counter) and for what **condition(s)**:

List significant **side effects**: _____

Record of Immunizations

| <i>Immunization</i> | <i>Year Primary Series Completed</i> | <i>Year of Last Booster</i> |
|--|--------------------------------------|-----------------------------|
| D.T.P. | _____ | _____ |
| Diphtheria | _____ | _____ |
| Pertussis (Whooping Cough) | _____ | _____ |
| Tetanus (must be within <u>last 10 years</u>) | _____ | _____ |
| Td | _____ | _____ |
| Oral Polio | _____ | _____ |
| Measles | _____ | _____ |
| Mumps | _____ | _____ |
| Rubella | _____ | _____ |
| Hep B | _____ | _____ |
| Tuberculin Test Given (Most Recent) | Date: _____ | Result: _____ |
| Other | _____ | _____ |

To the Physician

Please Sign Here:

Physician's Name _____

Physician's Signature _____ Date _____

Address _____

Phone _____ Fax _____