2020 HEALTH HISTORY/EXAMINATION FORM

Directions for Completion:

1. **Parent of guardian must complete Child Information, Emergency Contact Information and insurance information.**
2. **A physician is to complete form AND sign pages #3 and #4 of this form. Parent or guardian must sign page #4.**
3. **Mail to Variety; P.O. Box 609; Worcester, PA 19490**
4. **While enrolled in Variety programs, this must be completed every 12 months**

Date of Application: ______________________

CHILD INFORMATION

Name: ____ **DOB:** ______________ **Age:** ________

Last First

Address:

Street City State Zip

Phone: ________________________ **Diagnosis:** ________________________________ **Child's Gender:** M / F

Parent/Caregiver Names (please indicate relationship to child): ____________________________________

____

Child Lives with: Mother / Father / Grandparent / Foster Parent / Other: ______________________

Alternate Phone (work or cell): ________________________ **Contact name**: __________________________

Email Address: ____

EMERGENCY CONTACT INFORMATION*

*Please fill out; if the above listed is unable to be reached in the case of an emergency, VCC will contact people listed below

Contact Name: ____________________________________ **Relationship to child/family:** __________________

Address:

Street City State Zip

Phone: ___________________________ **Alternate Phone (work or cell):** ___________________________

Email Address: ____

Contact Name: ____________________________________ **Relationship to child/family:** __________________

Address:

Street City State Zip

Phone: ___________________________ **Alternate Phone (work or cell):** ___________________________

Email Address: ____

INSURANCE INFORMATION

YES NO

Is the participant covered by family medical/health insurance?

If YES, List Carrier: ____________________________ Group #: _______________________

*****PARENTS, PLEASE SIGN LAST PAGE OF FORM!*****

****THE INFORMATION BELOW MUST BE COMPLETED BY A PHYSICIAN****

BASELINE VITAL SIGNS:

Temp: _______ Pulse: ________ Respirations: ________ Blood Pressure: ________ Height: ________ Weight: ________

HEALTH HISTORY:

Please list any injury, illness, or infectious diseases within the last 6 months: ______________________________________

____

Please indicate any chronic or reoccurring illness or conditions: ____

____

Please indicate any hospitalizations and/or surgeries and dates occurred: ___________________________________

____

ALLERGIES:

YES NO

Medications If YES, which ones?

____

Foods If YES, which ones? ____

Insect bites If YES, how are reactions treated? ____

Pollen/outdoors If YES, are reactions treated? ____

IMMUNIZATIONS:

Which of the following has the child had? Measles Chicken Pox German Measles Mumps Hepatitis B Hepatitis C

PDD: Date of last test: __________________________________ Results? Positive Negative

If negative, date of last chest x-ray: __________________ Results? Positive Negative

Vaccine	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year
DTP						
TD						
Tetanus						
Polio						
MMR						
Or Measles						
Or Mumps						
Or Rubella						

Influenza B						
Hepatitis B						
Varicella						
Pneumonia						

Please list immunization dates for the following:*

*Electronic print of immunization record is acceptable.

PHYSICAL ASSESSMENT:

Psycho/Social System: ______________________________

Cardio-Vascular System: ______________________________

Respiratory System: ______________________________

Neurological System: ______________________________

Skeletal System: ______________________________

Muscular System: ______________________________

Integumentary System: ______________________________

Endocrine System: ______________________________

GI System: ______________________________

GU System: ______________________________

Reproductive System: ______________________________

MEDICATIONS:

***Please include prescription, over-the-counter, non-prescription drugs and tube feedings taken routinely**

This child takes **NO** medications on a routine basis
This child takes medications as follows:

Medication (Type/Name)	**Dosage** (mg/ml)	**How Administered?** (Mouth? Feeding tube? Crushed? Etc.)	**Frequency** (#/day)	**Times** (AM/Lunch/PM/Bed)

*Please attach any additional pages as needed; endorse each with physician signature.

Physician's Name: ____

Physician's Signature: ____

Date: ______________________________

OVER-THE-COUNTER MEDICATION:

Below is a list of over-counter medications that will be available to your child while participating in Variety Club Camp and Developmental Center programs. Please complete the information requested.

My child, (full name) ____________________, may have the following medication(s) as needed while at camp. Medication will be given as directed on the label, unless otherwise instructed by physician.

Please circle "Yes" to all that may apply; if they do not apply to your child, circle "No."

Tylenol*	Yes	No
Cough Medication	Yes	No
Cold Medication	Yes	No
Ibuprofen*	Yes	No
Laxative	Yes	No
Antacid*	Yes	No
Anti-diarrhea	Yes	No
Benadryl	Yes	No

*Indicates medication that is most often required

Please list any allergies: ____

____

____

Parent/Caregiver Name: ____ **Date:** _________________

Parent/Caregiver Signature: ____

Physician Name/Organization: ____

Physician Signature: ____ **Date:** ________________

Physician Address: ____

____

Physician Phone: ___________________________________ **Fax:** ________________________________