

2021 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; 2950 Potshop Road, P.O. Box 609; Worcester, PA 19490 ATTN: Nick Larcinese
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:** _____