Health Information

School/Group Name: _____ **Date Completed**: _____

Participant

Last Name: _____ First Name: _____ Birthdate: _____

Parent/Guardian 1

Last Name: _____ First Name: _____

Phone: _____ 2nd Phone: _____

Parent/Guardian 2

Last Name: _____ First Name: _____

Phone: _____ 2nd Phone: _____

Additional Emergency Contact

Last Name: _____ First Name: _____

Phone: _____ 2nd Phone: _____

Allergies

Please list any allergies and the reaction seen:

_____

_____

Diet

Check all that apply:

- ❏ No Restrictions
- ❏ Vegetarian
- ❏ Vegan
- ❏ Gluten Free
- ❏ Lactose Free
- ❏ Other (please explain)

Concerns or Restrictions

Please explain any medical, psychological, or developmental conditions or past events which could impact the participation of this child in Hosmer Point programs, or influence emergency medical treatment:

_____

_____

_____

_____

_____

Medical Insurance

Insurance Company: _____ Policy Number: _____

Subscriber Name: _____ Insurance Company Phone Number:_____

Medications

Please list all medications taken by this person, including over-the-counter drugs, vitamins, and natural remedies. Send all medications in their original pharmacy containers with labels showing the participant's name and how they should be given.

Medication Name	Dosage Amount	When Given

The following non-prescription medications and products are kept in the Hosmer Point health center and may be used on an as-needed basis to manage illness or injury. **Please check any medications or products this person should NOT be given without first contacting a parent or guardian:**

- ❏ Acetaminophen (Tylenol)
- ❏ Antihistamine (Benadryl)
- ❏ Antiacids (Tums)
- ❏ Ibuprofen (Advil, Motrin)
- ❏ Sunscreen
- ❏ Calamine lotion
- ❏ Cough Drops
- ❏ Antibiotic ointment
- ❏ Aloe Gel
- ❏ Insect repellant with DEET

Anything Else?

Is there anything else we should know about this person to ensure they stay safe and healthy?

_____

_____

Medical Release

I give permission for staff from Hosmer Point camp and/or (school / group name) _____ to provide routine health care, to administer prescribed medications, and to administer emergency treatment for me/my child; including but not limited to X-rays, routine treatment, and hospitalization; and to provide or arrange for necessary related emergency transportation. I also agree to the release of any medical records necessary for treatment, referral, billing, or insurance purposes.

If this person is a minor, it is my intention that representatives of this organization be considered "personal representatives" for the purpose of disclosing health information that is protected under the Health Insurance Portability and Accountability Act of 1996. I also agree to the disclosure to group representatives of protected health information of the person named herein so that they can keep me informed of my child's health situation.

In the event that I cannot be reached in an emergency, I give permission to the physician selected by the organization named herein to secure and administer treatment, including hospitalization, for the named person.

I have fully completed my child's health information and believe it to be a complete record of their known health conditions. I have carefully read the statements above and understand them to be a legally binding agreement.

I signify my acceptance of the above statements, terms, and conditions by signing below.

Signature of Participant (or Parent or Guardian if a Minor): Date:

_____ _____