

KEIO ACADEMY OF NEW YORK

Bilingual Summer Program Office

Tel: (914) 701-3454

SUMMER PROGRAM 2010 HEALTH REPORT FORM

**Health history must be filled out by parents/guardian.
Health exam must be completed by a licensed medical personnel.**

Name: _____ Birth Date: _____
Last First Middle

Home Address: _____

Social Security Number of Participant (if any): _____ Gender: ___ Male ___ Female

Parent/guardian: _____ Phone (home) _____ (cell) _____

Home Address: _____
(If different from above) Street Address City State Zip

Business Address: _____ Phone: _____
Street Address City State Zip

Second parent, guardian, or emergency contact: _____

Address: _____ Phone: _____
Street Address City State Zip

Business Address: _____ Phone: _____
Street Address City State Zip

Mandated by State

Parent/Guardian Authorizations: This health history is correct and complete to the best of my knowledge. The person herein described has permission to engage in all program activities except as noted.

Consent for Treatment and Transportation:

I hereby give my permission to the authorize personnel of Keio Academy Summer Program to provide routine health care, administer prescribed medication/s and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes.

I give permission to the program to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Keio Academy of NY to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of program. I also understand and agree to abide by any restrictions placed on my child's participation in program activities.

Signature of parent/guardian _____

Printed Name _____ Date _____

Meningitis Waiver *Mandated by State*

New York State Public Health Law requires the operator of an overnight children's program to maintain a completed response form for every participant who attends program for seven (7) or more days. Check one and sign below. For more information about meningococcal disease, please go to Center for Disease Control and Prevention website (www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf).

_____ My child has had the meningococcal meningitis immunization (Menomune/Menactra) within the past 10 years. Date received: _____
[Note: The vaccine's protection last for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.]

_____ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

Signed: _____ Date: _____
(Parent/Guardian)

PARENT

Please double check to see that all information is filled in correctly and checked, and all signatures are in place.

PARENT'S SECTION (Must be completed by parent/guardian)

Health History

ALLERGIES:

List all known allergies and describe reaction and management of reaction on spaces provided below.

No known allergies

RESTRICTIONS:

The following restrictions apply to this individual:

Dietary:

- | | | |
|---|---|--|
| <input type="checkbox"/> Does not eat red meat | <input type="checkbox"/> Does not eat pork | <input type="checkbox"/> Does not eat eggs |
| <input type="checkbox"/> Does not eat poultry | <input type="checkbox"/> Does not eat seafood | <input type="checkbox"/> Does not eat dairy products |
| <input type="checkbox"/> Others (specify below) | | |

Activities: Please explain if any (e.g. what cannot be done, what adaptations or limitations are necessary)

GENERAL QUESTIONS: (Please check YES or NO and explain "yes" answers on spaces below)

Has/Does the participant:	YES	NO		YES	NO
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	16. Have an orthodontic appliance brought to program?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have any skin problems (e.g. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	20. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts, or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	21. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	22. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	23. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	24. Ever had problems with joints (e.g. knees, ankles?)	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	25. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers, noting the number of the question.

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the program should be aware.

Name of family physician _____ Phone _____
Address _____

Name of family dentist/orthodontist _____ Phone _____
Address _____

PHYSICIAN'S SECTION (Must be completed and signed by examining physician)

Student's Name: _____
Last Name First Name Middle Name DOB

BP _____ Pulse _____ Resp. _____ Temp _____ Weight _____ Height _____

The student is is not able to participate in strenuous physical activities.

The student is under the care of a physician for the following conditions:

Known Allergies: _____ NKA _____ Others (specify below) _____

Description of any limitations or restrictions on program activities: _____

Medications to be Administered at program:

Please check next to the following medications to authorize their utilization per package instructions for age and or weight:

- Acetaminophen Ibuprofen Phenylephrine Loratadine 1% Hydrocortisone Cream
 Robitussin Dramamine Benadryl Bacitracin ointment Maalox /Rolaids Imodium

Additional Medications and or Treatments to be administered while at program:

Medication/Treatment Name	Dosage	Frequency/Schedule

Check box if the participant has had:

- Measles Chicken Pox German Measles Mumps Hepatitis A B C

Please give dates of immunization:

Vaccine	Dates					Vaccine	Dates			
	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr		Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DPT						Haemophilus Influenza B				
TD (tetanus/diphtheria)						Hepatitis B				
Tetanus						Varicella (chicken pox)				
Polio						Meningitis				
MMR						BCG (if any)				
Measles or						TB Mantoux Test Results	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative		
Mumps or						Date of last PPD test	_____			
Rubella						Chest X-ray (if positive PPD) Date:	_____	Result:	_____	

Signature of Licensed Medical Personnel/Physician: _____

Print Name: _____ Title: _____

Address: _____ Phone: _____

Date of Physical Examination (Must be done within 12 months prior to program attendance): _____

Self Care/Self Administration

Students who need to carry any medication dispensed by school nurse:

I request that the above named child be permitted to administer his/her medications under the supervision of a staff member of the program. She/he has been instructed in and understands the medication's purpose, frequency, and appropriate method of use.

Physician's Printed Name Signature Date

As I consider him/her responsible, I will not hold Keio Academy of New York personnel responsible for any problems that may arise with regards to my child's self-administered medication.

PARENT Signature

Parent's Printed Name Signature Date