RESIDENTIAL HEALTH INFORMATION FORM (Part 1)

BE COMPLETED BY STUDENT'S PARENT OR GUARDIAN

ALL BELOW FIELDS ARE REQUIRED

Student Information

Name of Student ______________________________ School District ______________________________

Address ____

Age _________ DOB _____/_____/____ Home Phone (__)______________________________ Gender ______________

Parent/Guardian Contact 1

Name of Parent/Guardian____

Address____

Home Phone (___)____________________ Cell Phone (___)____________________Email______________________________

Business Address:____ Phone (__)____________________

*** Parent/Guardian Contact 2 (If Applicable)**

Name of Parent/Guardian____

Address____

Home Phone (__)____________________ Cell Phone (___)____________________ Email______________________________

Business Address:____ Phone (__)____________________

Name and phone numbers of two ADDITIONAL adults we can contact in the event you cannot be reached:

Name__________________________ Relationship:______________ Phone (__)____________Cell Phone (___)____________

Name__________________________ Relationship:______________ Phone (__)____________Cell Phone (___)____________

Name of Family Doctor____ Phone (__)________________________

Health Insurance Carrier____ Policy #________________________

By signing below, I attest that all of the above information is accurate and up to date. I also give permission to Marine Studies Enrichment Program staff to contact any of the above noted parties.

SIGNATURE____ DATE__________________________

(Parent or Legal Guardian)

RESIDENTIAL HEALTH INFORMATION FORM (Part 2)
TO BE COMPLETED BY STUDENT'S PARENT OR GUARDIAN

ALL BELOW FIELDS ARE REQUIRED

Does your child have any known limitations that would prevent them from participating in any physical activities?

Please circle: Yes / No

If you circled yes to the above question, please state and describe the limitations in the space below.

____

____

____.

Does your child have any known special needs? (i.e. ADHD, Anxiety, etc.)

Please circle: Yes / No

If you circled yes to the above question, please describe in the space below.

____

____

____.

My child has permission to carry and use sunscreen and/or insect repellent. Camp staff can assist with the application of sunscreen and/or insect repellent if my child is unable to do so, provided my child requests the assistance.

The student herein described has my permission to engage in all prescribed activities except as noted by me and/or the student's physician. In the event I cannot be reached in an emergency, I hereby give my permission to the physician, selected by the teacher in charge, to provide first aid treatment as needed.

SIGNATURE____ DATE________________________

(Parent or Legal Guardian)

RESIDENTIAL HEALTH INFORMATION FORM

TO BE COMPLETED BY STUDENT'S ***PHYSICIAN OR NURSE***

Name of Student ____ School District _____________________________________

Address ____

Age __________ DOB _____/_____/_____ Home Phone (___) __________________________________ Gender __________________

Name of Parent/Guardian____ Cell Phone (___) _____________________________

Required Complete Vaccinations:

- Tetanus
- Measles
- Varicella
- Diphtheria
- Rubella
- Pertussis
- Mumps
- Poliomyelitis
- Meningococcal
- Hepatitis B
- Hemophilus B

*** Please include a complete copy of immunization records***

1. List any health conditions, such as heart disease, diabetes, epilepsy, asthma, or any chronic condition, etc.:

   ____

2. Does the student have any condition that requires medication? If yes, what is the condition and treatment?

   ____

****If medication needs to be administered (prescription and/or over-the-counter), the doctor-signed "Parent and Provider Permission to Administer Medication" form must be completed for each medication and attached to this health form. Prescription medication must be sent in original pharmacy containers.****

4. Does student carry an inhaler, Epi-pen and/or have diabetes? __________ If yes, the "Provider Attestation and Parent Permissions for Independent Medication Carry and Use" must also be completed on the "Parent and Provider Permission to Administer Medication" form.

5 Please indicate if the student has an allergy, its symptoms and the treatment below. If no, please write "no."

Type	Yes / No	Specify	Symptoms	Treatment
Food				
Insect sting				
Medication				
Other				

6. Has student been exposed to any communicable diseases in the past 21 days? Circle: Yes / No
   If yes, please indicate disease(s):____

7. Do you know of any health factor that makes it advisable for student to follow a limited program of physical activity?
   Circle: Yes / No If yes, please state and describe any limitations.____

8. Does student wear glasses? Circle: Yes / No 9. Contact lenses? Circle: Yes / No

10. Dietary restrictions, if any: Circle: Yes / No ____

SIGNATURE____ DATE______________________

Physician or Nurse (Circle One: MD, DO, NP, PA or RN)