HEALTH RECORD FOR YOUTH Form

(This side is to be completed by Parent before presenting to Physician)

NAME OF PROGRAM: _____

Youth's Last Name: _____ **Youth's First Name:** _____

Gender: Male ☐ Female ☐ **Date of Birth:** (Month/Day/Year) _____/_____/_____

Home Address: _____ Apt # _____

City: _____ **State:** _____ **Zip:** _____

Phone (Home): _____ (Cell): _____

Parent's or Guardian's Name: _____ Phone _____

Father's Place of Employment: _____ Phone _____

Mother's Place of Employment: _____ Phone _____

In case of emergency, notify: _____ Phone _____

If parent or guardian is not available in an emergency, notify: (family physician)

1. _____ Phone _____

2. _____ Phone _____

IMPORTANT. Please notify RISE Program Staff if child was/is exposed to any communicable disease at anytime three weeks prior to attendance: No ☐ Yes ☐

If "Yes", please give type of exposure _____

_____

HEALTH HISTORY (check, giving approximate dates)

- ☐ Asthma: _____
- ☐ Behavior: _____
- ☐ Convulsion: _____
- ☐ Chicken Pox: _____
- ☐ Diabetes: _____
- ☐ Ear Infection: _____
- ☐ Hay Fever: _____
- ☐ Insect Stings: _____
- ☐ Ivy Poisoning, etc: _____
- ☐ German Measles: _____
- ☐ Measles: _____
- ☐ Mumps: _____
- ☐ Past Illness: _____
- ☐ Contagious Illness: _____
- ☐ Other drugs: _____
- ☐ Penicillin: _____
- ☐ Rheumatic fever: _____
- ☐ Operations or serious injuries (dates): _____
- ☐ Hospitalization: _____
- ☐ Chronic or recurring illness: _____
- ☐ Other diseases or details of above: _____

Any specific activities to be encouraged? _____

_____

Any specific activities to be restricted _____

_____

Permission for all program activities unless otherwise noted by physician: _____

_____

Suggestion from Parent(s) or Guardian: _____

_____

_____

SIGNIFICANT HEALTH HISTORY AND CURRENT CONDITIONS

Please list: _____

_____

Medication taken _____

_____

Appliance worn (Glasses, Hearing Aid, etc): _____

_____

Conditions that modify activity (seizures, asthma, heart condition, etc): _____

_____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I hereby give my consent/authority to RISE Staff to obtain the necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship _____

Signature _____

Telephone _____

Date _____

The purpose of this health record is to provide the staff with pertinent information, which will help to serve the need of the aforementioned Youth in RISE programs. (To be filled out by Physician – Please note information on reverse side)

IMMUNIZATION HISTORY

(This is a record of dates of basic immunization and most recent booster doses)

DPT or DT or TD	Date:		Date:		Date:		Date:		Date:	
POLIO	Date:		Date:		Date:		Date:		Date:	
MEASLES	Date:									
MUMPS	Date:									
RUBELLA	Date:									

(PPD-MANTOUX)

Tuberculin Test given: _____(most recent) Result ☐ **m** ☐ **m**

MEDICAL EXAMINATION (To be completed by licensed Physician)

Examination is acceptable when performed no more than 12 months prior to arrival at camp.

CODE: **S** = **Satisfactory** / **X** = **Not Satisfactory** (Explain) / **O** = **Not Examined**

General Appearance: _____

Height _____ Glasses _____ Teeth _____ Describe abnormal findings and/or handicapping conditions

Weight _____ Extremities _____ Abdomen _____

Blood pressure _____ Heart _____ Hernia _____

HGB Test _____ Ears _____ Genitalia _____

Urinalysis _____ Hearing _____ Allergy (Please specify) _____

Posture & Spine _____ Feet _____

Throat/Tonsils _____ Lungs _____ Neurological findings _____

Eyes _____ Skin _____

Vision _____ Nose _____

Has child ever received products containing horse serum? No ☐ Yes ☐ If "Yes", please explain _____

Special diet _____

Medication (give name and dosage) _____

Parent/Guardian seeking special medication? _____

Swimming _____

Diving _____

Strenuous Activity _____

General appraisal _____

HAVE EXAMINED THE INDIVIDUAL HEREIN DESCRIBED, REVIEWED HIS/HER HEALTH HISTORY AND IT IS MY OPINION THAT HE/SHE IS PHYSICALLY ABLE TO ENGAGE IN RISE PROGRAMS AND YOUTH ACTIVITIES, EXCEPT AS NOTED ABOVE.

PHYSICIAN SIGNATURE _____ M.D.

DATE _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____