33 Clearpool Road
Carmel, NY 10512
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green chimneys
clearpool campus

REQUIRED MEDICAL HISTORY

(Parent or Legal Guardian to Complete)

Participant's Name _____ **Date of Birth** _____
Address_____ **Phone#:** _____
_____

Group Attending Clearpool with (school/organization name) ___

Emergency Notification:
With whom does child reside and what is / are his / her relationship(s) with the child? _____
Parent 1 Name_____ Phone: Home _____Work _____ Cell _____
Parent 2 Name_____ Phone: Home _____Work _____ Cell _____

Person to contact in an emergency if parents are unavailable:
Name:_____ Phone: Home_____ Work _____Cell _____
Physician:_____ Phone _____
Dentist/Orthodontist:_____ Phone_____

Emergency Medical Information (check yes or no)

Yes___ No___ Allergy to a medicine, food, plant, animal, or insect
Yes___ No___ Do you have an epinephrine pen?
Yes___ No___ Any condition that requires special care, medication or diet
Yes___ No___ Asthma
Yes___ No___ Contact Lenses
Yes___ No___ Seizure Disorder
Yes___ No___ Diabetes
Yes___ No___ Heart Trouble
Yes___ No___ Bleeding Disorder
Yes___ No___ Dentures
Yes___ No___ Bonded Teeth

Explain any of the above:_____
_____

Medical History (check yes or no)

	Yes	No	Date	Details
Serious illness	_____	_____	_____	_____
Serious injury	_____	_____	_____	_____

Does your child have frequent: (circle yes or no)
Y / N Eye Infections
Y / N Ear Infections
Y / N Throat Infections
Y / N Respiratory Infections
Y / N Urinary Tract Infections
Y / N Vaginal Infections

Does your child have: (circle yes or no)
Y / N Heart Murmur
Y / N Rheumatic Fever
Y / N Stomach/Intestinal Problems
Y / N Menstrual Problems
Y / N Hernia
Y / N Back or Joint Pains

Explain any of the above:_____
Has this person had Chicken Pox? ( ) Yes ( ) No If yes, when? Date_____
Has this person had Mumps? ( ) Yes ( ) No If yes, when? Date _____
Has this person been exposed to a contagious disease within the past three weeks? _____
Has this person had lice in the past six months? _____
If applicable, has this person started menstruation? ( ) Yes ( ) No Has she been told about menstruation? ( ) Yes ( ) No
Does this person take <u>any</u> medication on a regular basis? Yes _____ No _____
Explain:_____

To the best of my knowledge, the above information is correct. I give my child permission to participate in all activities and trips.
In the event of accident or illness, I authorize the Green Chimneys to institute and obtain medical care.
**** In the event of a communicable disease outbreak, I understand this person will be excluded from trip if not fully immunized.**

DATE_____ **SIGNATURE (parent or legal guardian)**_____

MEDICAL EVALUATION

(To be completed by physician)

Name_____ Date of Birth_____
Month/Day/Year

has had a complete history and physical exam on_____
Month/Day/Year

Disease Assessment

Yes	No			Date of Onset
☐	☐	Asthma	☐ Mild ☐ Moderate ☐ Severe ☐ Exercise Induced ☐ Unclassified	
☐	☐	Diabetes	☐ Type I ☐ Type II	
☐	☐	Anaphylactic Reaction	☐ Food ☐ Insect ☐ Latex ☐ Other: Explain	
☐	☐	Seizure Disorder	Type:	
☐	☐	Chicken Pox	If yes, when?	
☐	☐	Mumps	If yes, when?	
☐	☐	Other: Please Specify		

Prescription Medication: Please complete with patient's current regimen for both scheduled and PRN medications including heparin flushes for central lines; please use additional paper if needed.

DRUG **ROUTE** **DOSAGE** **FREQUENCY** **COMMENTS**

_____

_____

_____

_____

Individualized Orders: The following Standard "Over the Counter / PRN Medications " are available in the Health Center to be administered if needed per the family physician's instructions.

*** * * THIS SECTION MUST BE COMPLETED * * ***

Drug Name (Generic equivalents may be used)	Dosage	Route	Indications	Healthcare Provider Permission	Comments
Diphenhydramine	As per pkg by wt. & age	PO	Allergies or Allergic Reactions	Yes / No	
Burn Gel	Apply to minor burns	Topically	Minor Burns	Yes / No	
Stool Softner	As per pkg by wt. & age	PO	No BM x 3 Days	Yes / No	
Acetaminophen	As per pkg by wt. & age	PO	Temp. ≥ 100°F or Pain	Yes / No	
Ibuprofen	As per pkg by wt. & age	PO	Temp. ≥ 100°F or Pain	Yes / No	
Hydrocortisone	Apply to effected area 3x/day	Topically	Itch	Yes / No	
Cough Drops	As per pkg by wt. & age	PO	Cough or Sore Throat	Yes / No	
Antacid	As per pkg by wt. & age	PO	Upset Stomach	Yes / No	
Antibiotic Oint.	Apply to effected area 3x/day	Topical	Scrapes or Cuts	Yes / No	

Emergency Medications:

Does this person require: Epi-pen: ☐ yes ☐ no PRN Inhaler: ☐ yes ☐ no

This person has permission to carry: Epi-pen: ☐ yes ☐ no PRN Inhaler: ☐ yes ☐ no

(Note: ability to carry implies ability to self administer)

If you have a Nut/Allergy Action plan please attach a copy

Name_____ Date of Birth_____

Additional Orders: As deemed necessary by health care provider to be implemented by an RN:
_____
_____
_____

Limitations on Activities: **S**wimming_____Diving_____Hiking_____Athletics_____Other:_____
Explain above:_____

HIPAA Privacy Statement: Permission to Release Confidential Health Information

I give _____ permission to release confidential health information
Name of Medical Practice
to Green Chimneys regarding this person _____ .
Name of Participant
Date _____ Parent/Guardian Signature _____

I certify that I have on this date examined the above named and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this child to participate in physically strenuous activities.

Signature of Physician_____ Date of examination _____

Physician's Name (please print) _____ License# _____

Address_____ Phone#_____

Parent/Guardian Signature _____ Date _____