MOORESTOWN FRIENDS SCHOOL
SUMMER PROGRAMS

MFS | 1785
Moorestown Friends School

Camper Health Information - Summer 2019

Today's Date _____

Student's Name _____

Are you an MFS Student? ☐ YES ☐ NO

MFS Students/Families: Please complete the following three questions ONLY. Then sign at bottom.

Is your medical information on file in the nurse's office? (Updated within the last 12 months) ☐ YES ☐ NO

Does your child have any allergies or medical alerts? ☐ YES ☐ NO

This child is allergic to:

☐ No known allergies ☐ Food ☐ Medicine ☐ Environmental (grass clippings, insect stings, hay fever, etc.)

☐ Other

Please describe alert here: _____

_____

Medication:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. Please send all medications in their original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire week.

Are you providing an EpiPen or prescription medication for your child? ☐ YES ☐ NO

Social and Emotional Health: Check "YES" or "NO" for each statement.

Has the child:

(turn to next page)

Student's Name _____

During the last 12 months seen a professional to address social/emotional health concerns

☐ YES ☐ NO

Even been evaluated for and/or diagnosed with attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)

☐ YES ☐ NO

Ever been treated for emotional or behavioral difficulties or an eating disorder

☐ YES ☐ NO

Please explain "YES" answers in the space below, noting the number of the question. The Program Director or Nurse may contact you for additional information.

General Health History: Check "YES" or "NO" for each statement/ Explain "YES" answere below.

Does the student:

Have asthma/wheezing/shortness of breath

☐ YES ☐ NO

Have diabetes

☐ YES ☐ NO

Wear glasses, contacts, or protective eyewear

☐ YES ☐ NO

Have problems with diarrhea/constipation

☐ YES ☐ NO

Please explain "YES" answers in this space, noting the number of the question.

Restrictions:

☐ I have reviewed the programs and activities of the camp and feel the child can participate WITHOUT restrictions.

Student's Name _____

I have reviewed the programs and activities of the camp and feel the child can participate WITH THE FOLLOWING RESTRICTIONS or adaptations:

Please describe here:

Immunization History:

Provide the month and year for each immunization. Starred (*) immnuizations must be current. Copies of immunization forms from health care providers or state or local governments are acceptable. You may: fill in the fields below, FAX to 856-235-6684, email your scanned document to the program director, or upload your document into the online registration system (follow prompts in "Document Center").

Diptheria, tetanus, pertussis* (DTaP) or (TdaP)
Doses in Month/Year

Tetanus booster* (dT) or (TdaP)
Most rcent Dose Month/Year

Mumps, measles, rubella* (MMR)
Doses in Month/Year

Polio* (IPV)
Doses in Month/Year

Haemophilus influenza type B (HIB)
Doses in Month/Year

Pneumococcal (PCV)
Doses in Month/Year

Hepatitis B
Doses in Month/Year

Hepatitis A
Doses in Month/Year

Varicella (Chicken Pox)
Doses in Month/Year

Had chicken pox? YES NO Date? _____

Meningococcal meningitis (MCV4)
Doses in Month/Year

Tuberculosis (TB) test
YES NO Date? _____

Student's Name _____

TB test results
Negative Positive

Student's Name _____

If your camper has not been fully immunized for religious exemption reasons, please sign the following statement: *I understand and accept the risks to my child from not being fully immunized* .

Signature of Custodial Parent/Guardian: _____

Date: _____

Relationship to Camper: _____

Medical Insurance Information/Healthcare Providers

This camper is covered by family medical/hospital insurance ☐ YES ☐ NO

Name of child's PCP _____

Phone # _____

What have we forgotten to ask?

Please provide in the space below any additional information about the student's physical, social or emotional health that you feel is important or that may affect the child's ability to fully participate in the program.

Permission to 'Treat' Authorization

I hereby give permission to the medical personnel to provide routine healthcare; to administer prescribed medications; and to administer emergency treatment for me/my child, including, but not limited to X-rays, routine tests and treatment and/or hospitalization; and to provide or arrange necessary related transportation for me/my child. I also agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

If the person named herin is a minor, it is my intention that representatives of the camp 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 camp representatives of protected health information of the person named herin in order to provide information related to the person's ability to participate in camp activities; and if the person named herin is a minor, to provide information to the camp representatives to keep me informed of my child's health situation.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the named person. This completed form may be photocopied for trips out of camp.

Student's Name _____

Camper Agreement

I understand and agree to abide by any restrictions placed on my activity at MFS Summer Programs.

Camper Initials _____

Today's Date: _____

Completion Acknowledgement

☐ Yes, this information is complete and accurate.

Parent/Guardian Signature Required

_____

_____