

**SUMMER PROGRAM  
BLACKSTONE VALLEY BOYS AND GIRLS CLUB  
MEMBER HEALTH HISTORY FORM**

To reserve your child's spot for the 2010 Summer Program, this form must be completed and submitted with the member's summer program registration form and a deposit of \$200 per child or full payment.

Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Health-Care Providers:**

Name of member's primary doctor(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of dentist(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of orthodontist(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Immunization History**

Provide the month and year for each immunization. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

<u>Immunization</u>	<u>Dose 1 Month/Year</u>	<u>Dose 2 Month/Year</u>	<u>Dose 3 Month/Year</u>	<u>Dose 4 Month/Year</u>	<u>Dose 5 Month/Year</u>	<u>Most Recent Dose</u>
Diphtheria, Tetanus, Pertussis (DTap) or (TdaP)						/ / / / /
Tetanus booster (dT) or (TdaP)	/ / / / /	/ / / / /	/ / / / /	/ / / / /	/ / / / /	
Mumps, Measles, Rubella (MMR)			/ / / / /	/ / / / /		
Polio (IPV)					/ / / / /	/ / / / /
Haemophilus influenzae type B (HIB)					/ / / / /	/ / / / /
Pneumococcal (PCV)					/ / / / /	/ / / / /
Hepatitis B				/ / / / /	/ / / / /	/ / / / /
Hepatitis A			/ / / / /	/ / / / /	/ / / / /	/ / / / /
Varicella Had Chicken Pox? Yes No	Date: _____	/ / / / /	/ / / / /	/ / / / /	/ / / / /	/ / / / /
Meningococcal Meningitis (MCV4)		/ / / / /	/ / / / /	/ / / / /	/ / / / /	/ / / / /
Tuberculosis (TB) test Date: _____ NEG POS	/ / / / /	/ / / / /	/ / / / /	/ / / / /	/ / / / /	/ / / / /

**Prescribed Medication**

\_\_\_ This member will not take any daily medications while attending camp.

\_\_\_ This member will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **Medication must be in original pharmacy containers with labels which show the member's name and how the medication should be given. Provide enough of each medication to last the entire time the member will be at camp.**

<b>Name of Medication</b>	<b>Date Started</b>	<b>Reason for taking it</b>	<b>When it is given (time)</b>	<b>Amount or dose given</b>	<b>How it is given</b>

**Allergies**

No Known Allergies \_\_\_

This member is allergic to: \_\_\_ Food \_\_\_ Medicine \_\_\_ The Environment \_\_\_ Other

Please describe below what the member is allergic to and the reaction seen:

## **Non-Prescribed Medication**

The following non-prescription medications may be stocked in the Club First Aid Room and are used on an as needed basis to manage illness and injury. ***Cross out those the member should not be given.***

Acetaminophen (Tylenol)  
Phenylephrine decongestant (Sudafed PE)  
Antihistamine/allergy medicine  
Diphenhydramine antihistamine/allergy medicine (Benadryl)  
Sore throat spray  
Lice shampoo or cream (Nix or Elimite)  
Calamine lotion  
Laxatives for constipation (Ex-Lax)

Ibuprofen (Advil, Motrin)  
Pseudoephedrine decongestant (Sudafed)  
Guaifenesin cough syrup (Robitussin)  
Dextromethorphan cough syrup (Robitussin DM)  
Generic cough drops  
Antibiotic cream  
Aloe  
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

## **General Health History**

***Circle "Yes" or "No" for each statement.***

Has/does the member:

- |  |     |    |  |     |    |
|--|-----|----|--|-----|----|
| 1. Ever been hospitalized? .....                       | Yes | No | 11. Had fainting or dizziness? .....                         | Yes | No |
| 2. Ever had surgery? .....                             | Yes | No | 12. Passed out/had chest pain during exercise? .....         | Yes | No |
| 3. Have recurrent/chronic illnesses? .....             | Yes | No | 13. Had mononucleosis ("mono") during the past 12 months?... | Yes | No |
| 4. Had a recent infectious disease? .....              | Yes | No | 14. If female, have problems with periods/menstruation?..... | Yes | No |
| 5. Had a recent injury? .....                          | Yes | No | 15. Have problems with falling asleep/sleepwalking? .....    | Yes | No |
| 6. Had asthma/wheezing/shortness of breath?.....       | Yes | No | 16. Ever had back/joint problems?.....                       | Yes | No |
| 7. Have diabetes? .....                                | Yes | No | 17. Have a history of bedwetting?.....                       | Yes | No |
| 8. Had seizures? .....                                 | Yes | No | 18. Have problems with diarrhea/constipation?.....           | Yes | No |
| 9. Had headaches? .....                                | Yes | No | 19. Have any skin problems?.....                             | Yes | No |
| 10. Wear glasses, contacts, or protective eyewear? Yes |     | No | 20. Traveled outside the country in the past 9 months?.....  | Yes | No |

***Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.***

## **Mental, Emotional, and Social Health**

***Circle "Yes" or "No" for each statement.***

Has the member:

- |  |     |    |
|--|-----|----|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? .....   | Yes | No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....  | Yes | No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....  | Yes | No |
| 4. Had a significant life event that continues to affect the member's life?.....<br>(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) | Yes | No |

***Please explain "Yes" answers in the space below, noting the number of the questions. The Club may contact you for additional information.***

## **Restrictions**

I have reviewed the program and activities of the program and feel the member can participate without restrictions.

I have reviewed the program and activities of the program and feel the member can participate with the following restrictions or adaptations:

## **What Have We Forgotten to Ask?**

***Please provide in the space below any additional information about the member's health that you think important or that may affect the member's ability to fully participate in the camp program. Attach additional information if needed.***