

Health History Form for students attending Triple Threat Camp

Mail this form to the address below, along with other registration materials

Early bird prior to 4/15; Late registration prior to 7/5

The School of Performing Arts, Inc.
200 E. 5th Avenue, Suite 132
c/o Theatre Office- Triple Threat Camp
Naperville, IL 60563

Dates of Camp Attendance: July 26 – July 31, 2010

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any additions to this form should be provided to the camp director in writing upon participant's arrival in camp- in writing. Provide complete information so that the camp can be aware of your needs.

Name _____ Birth Date _____ Age at camp ____
Last First Middle

Home Address _____
Street Address City State Zip

Social Security Number of Participant _____ Gender: Male Female

Custodial parent/guardian _____ Phone _____
Home Work Cell

Home Address _____
Street Address City State Zip

Business Address _____
Street Address City State Zip

Second parent/guardian or emergency contact _____

Phone _____
Home Work Cell

Home Address _____
Street Address City State Zip

Business Address _____
Street Address City State Zip

If not available in an emergency, notify _____

Relationship _____ Phone _____
Home Work Cell

Address _____
Street Address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____

Sponsor/Employer Name (if applicable) _____

**Photocopy of front and back of health insurance card must be attached to the bottom of this form.*

SUBMIT AND COMPLETE THIS FORM BY JULY 5 2010

Important- These boxes must be complete for attendance

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted below. I hereby give permission to the camp to provide, seek and consent to routine health care, administration of prescribed medications and emergency treatment for me/ my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" on behalf of me for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree to the disclosure to camp representatives of the protected health information of the person herein described, as necessary, for camp representatives or any attending physician to be involved in the person's health care or payment for care, including (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status. In the event I cannot be reached in an emergency as determined by any camp representative, or a physician, nurse or paramedic, I hereby give permission to the attending physician to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied, as necessary.

Signature of parent/guardian (or camp staffer in the event this form is for him/her) X _____
Printed Name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor/camper attending Triple Threat X _____
Printed Name _____ Date _____

ALLERGIES List all known

Describe reaction and management of the reaction

Medication allergies (list)

Food allergies (list)

Other Allergies (list)- include insect stings, hay fever, asthma, animal dander, etc.

Have you explained to and does your child know his/her allergies? Yes No

MEDICATIONS BEING TAKEN

Please list ALL medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

This person **takes NO medications** on a routine basis. OR This person **TAKES MEDICATIONS** as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

*Attach additional pages for more medications.

Also, identify any medications taken during the school year that participant does/may not take over the summer: _____

Have you explained to and does your child know what medications and when to take them? Yes No

RESTRICTIONS (The following restrictions apply to this individual)

Does not eat: Red meat Pork Dairy Products Poultry Seafood Eggs Other _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) _____

SUBMIT AND COMPLETE THIS FORM BY JULY 5 2010

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/conditions?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever Been Hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance at camp?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever Had Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (rash acne, itching)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bedwetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties needing help?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain "yes" answers, noting the number of the questions.

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

Please give all dates of immunization for:

Vaccine: _____ Dates: _____ Mo/Yr

- DTP
- TD (tetanus/diphtheria)
- Tetanus
- Polio
- MMR
- (or measles, mumps or rubella)
- Haemophilus influenza B
- Hepatitis B
- Varicella (chicken pox)
- TB Mantoux Test

Date of last test _____

Result: Positive Negative

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware.

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

SCREENING RECORD (for camp use only)

Date screened _____ Time _____ (am/pm) Screened by _____

Meds received _____

Observation notes _____

SUBMIT AND COMPLETE THIS FORM BY JULY 5 2010