

STAGEDOOR MANOR PERFORMING ARTS TRAINING CENTER
Health History and Physician's Examination

NAME: _____ Gender: M F Age: _____ Birthdate: _____
 ADDRESS: _____ CITY CODE: _____ COUNTRY CODE: _____
 PHONES Home: _____ Cell: _____

Emergency Contact 1: _____ Relationship: _____
 Address: _____
 Phones Home _____ Cell _____ Work _____

Emergency Contact 2: _____ Relationship: _____
 Address: _____
 Phones Home: _____ Cell _____ Work _____

Insurance Information: fill out information below. A photocopy of the front and back of your health insurance card must be attached.
 Policy Holder: _____ Insurance Carrier: _____ Policy #: _____
 Carrier Address: _____ Carrier Phone Number: _____

Primary Care Physician: _____ Phone: _____
 Dentist: _____ Phone: _____
 Other Physician: _____ Phone: _____

This Health Form is correct and complete as far as I know. I understand and agree to abide by any restrictions placed on my participation in camp activities by the examining medical personnel.
 I hereby give permission for me to receive necessary medical care while at camp, including tests and medications. I give permission for camp to release any records required for necessary care and/or for insurance purposes. In case I cannot respond in an emergency, I hereby give permission to the physicians and hospitals selected by camp to administer treatment, including hospitalization.

Signature of Staff Member: _____ Date: _____

HEALTH HISTORY:

Allergies: Medications No Yes List: _____
 Food No Yes List: _____
 Bee Sting No Yes List: _____
 Other No Yes List: _____

Are any specific medications required to address any of these allergic reactions? If yes, please explain and provide the medication with clearly marked instructions. _____

Are there any dietary restrictions or issues? Please explain: _____

IMMUNIZATION HISTORY: Please record dates of basic immunizations

<i>Immunization</i>	<i>Date Initial series &/or booster</i>	<i>Immunization</i>	<i>Date Initial series &/or booster</i>	<i>Immunization</i>	<i>Date Initial series &/or booster</i>
DTP		MMR		Varicella	
TD		Or Measles		Meningococcal	
Tetanus		Or Mumps		TB test date:	
Polio		Or Rubella		TB test results: <input type="checkbox"/> positive <input type="checkbox"/> negative	
H. Influenza B (HIB)		Hepatitis A			
Influenza/H1N1		Hepatitis B		Other:	

PRESCRIPTION MEDICATIONS (Please complete with current regimen for both daily and PRN medications.)

Drug	Route	Dosage	Frequency	Indication for Use

HEALTH HISTORY: Please indicate **YES** or **NO** and give approximate dates

DISEASE	YES	NO	DATE	DISEASE	YES	NO	DATE	DISEASE	YES	NO	DATE
Asthma				Fainting				Immune Disorder			
Blood Disorders				Headache/Migraine				Joint Disorders			
Diabetes				Heart Condition				Kidney Disorders			
Depression				Hepatitis A - B - C				Seizures/Epilepsy			
Eating Disorders				Hypertension				Spine/Back			

Please explain any YES answer: _____

Chronic or recurring illness not mentioned above: _____

Operations or serious illnesses? _____

Recent illness, injury, or infectious disease? _____

Any history of emotional or mental disturbances? Yes No If yes, please explain: _____

(Female) Is menstrual history normal? Yes No If no, are special considerations needed? _____

TO THE PHYSICIAN: This person will serve up to four months in the USA as a leader in a summer theater camp for children or as support staff in the kitchen, office, or maintenance department. Your careful examination and written recommendations will encourage physical wellness and safe participation in camp activities.

PHYSICIAN'S EXAMINATION:

Weight: _____ Height: _____ BP: _____

Allergies (please specify allergen and reaction): _____

EXAM: Please indicate whether the following are satisfactory (S), unsatisfactory (U) or not examined (NE):

Eyes	Lungs	Skin
Ears	Heart	Extremities
Nose	Hernia	Posture (Spine)
Throat	Abdomen	Genitalia

General appraisal: _____

Any restrictions on: Swimming ____ Tennis ____ Aerobics ____ Strenuous Activities ____ Other: _____

Additional information for the health care staff at the camp: _____

FOR PHYSICIAN: I have examined this person, have reviewed the health history and prescribed medications as indicated. It is my opinion that this person is physically able to engage in camp activities, except as noted above.

Licensed Provider's Signature

Printed Name of Provider

Address

Phone

Date of Exam