Dragons Haven
Health Form

Event Dates: June 8-10th, 2018

The health form is kept confidential and used by our health services staff (or emergency medical personnel). **Every student needs a completed health form to participate. Please fill out this form as completely as possible.** Thank you!

SECTION I – BASIC CONTACT INFORMATION

Student Name_____
LAST FIRST MIDDLE

Birth date_____/_____/_____ Age _____ Gender _____

Home Address_____
STREET CITY STATE ZIP

Home Phone_____

Parent/Guardian #1 Name_____

Relationship:_____

Day Phone_____ Night Phone_____

Day Phone is ☐ Home ☐ Work ☐ Cell Night Phone is ☐Home ☐ Work ☐Cell

Parent/Guardian #2 Name_____

Relationship:_____

Day Phone_____ Night Phone_____

Day Phone is ☐ Home ☐ Work ☐ Cell Night Phone is ☐Home ☐ Work ☐Cell

Additional Emergency Contact_____ Relationship_____

(In case we can't reach YOU)

Day Phone_____ Night Phone_____

Day Phone is ☐ Home ☐ Work ☐ Cell Night Phone is ☐Home ☐ Work ☐Cell

Family Physician Name_____ Phone_____

Dentist/Orthodontist Name_____ Phone_____

SECTION II – INSURANCE INFORMATION

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

If yes, indicate Insurance Carrier_____

Group #_____ Policy #_____

Policy Holder's Name_____ Relationship to participant_____

SECTION III – MEDICATIONS

Will student be taking medications while at the event? □ Yes □ No *(Medications include prescription, over-the-counter, vitamins, inhalers, etc.)*

If student will be taking medications while at the event, it is MA state law to secure your consent for medication distribution and for the use of medical devices. The medication can be self-administered (if over 18) or administered by Health Services Staff. Please list all (prescription and non-prescription).

Include the medication name, prescribing physician, physician's phone number, and the dosage instructions. Use an additional sheet if needed. When you check-in at the event, please provide all medications (in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration).

_____ I want the medication or medical devices self-administered. (**Age 18 and above only**.)
_____ I want the medication or medical device administered by the Health Services Staff. However, a limited amount of medication for life threatening conditions should be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

Medication_____ Dosage_____ Take at what times_____
Reason for Taking_____
Prescribing Physician_____ Phone_____

Medication_____ Dosage_____ Take at what times_____
Reason for Taking_____
Prescribing Physician_____ Phone_____

Medication_____ Dosage_____ Take at what times_____
Reason for Taking_____
Prescribing Physician_____ Phone_____

SECTION IV – ALLERGIES

□ Student does not have any Allergies
Student has exceptional allergic sensitivity to:
□ 1. Hay Fever □ 2. Poison Ivy/Oak □3. Insect Stings □ 4. Food □ 5. Penicillin □ 6. Other Drugs □ 7. Other
List allergy. Describe reaction and treatment
_____
_____
_____

SECTION V – IMMUNIZATIONS

Please record the month and year of immunizations. If you do not know the dates or whether student has had certain immunizations, simply leave blank.

DPT (Diphtheria, Pertussis, Tetanus)..... _____
Tetanus Booster ..... _____
Polio..... _____
MMR (Measles, Mumps, Rubella)..... _____
HIB (Haemophilus Influenza B)..... _____
Tuberculin Test ..... _____
Varicella (Chicken Pox)..... _____
Hepatitis B ..... _____

SECTION VI – HEALTH HISTORY

Please know that we value your privacy. Health History information is available only to the health staff. The more information you provide, the better we can do our job. Thanks!

Has the student had a history of or are they prone to any of the following (Please check all that apply).

☐ 1. Recent injury, illness or infectious disease
☐ 2. Chronic or recurring illness
☐ 3. Asthma
☐ 4. Homesickness
☐ 5. Frequent Ear Infections
☐ 6. Seizure Disorder or Convulsions
☐ 7. Dizziness during or after exercise
☐ 8. Chest pain during or after exercise
☐ 9. Heart Defect/Disease
☐ 10. Hypertension
☐ 11. Bleeding/Clotting Disorders
☐ 12. Diabetes
☐ 13. Mononucleosis (in last 12 months)
☐ 14. Chicken Pox
☐ 15. Measles
☐ 16. German Measles
☐ 17. Mumps
☐ 18. Tuberculosis
☐ 19. Hepatitis
☐ 20. Joint problems (knees, ankles)
☐ 21. Fractures
☐ 22. Frequent Headaches
☐ 23. Head Injury
☐ 24. Eating Disorder
☐ 25. Diarrhea or constipation
☐ 26Frequent Stomachaches
☐ 27Wears glasses or contacts
☐ 28Been Hospitalized
☐ 29Wears a Medic Alert ID

Please list the number and provide explanation for any checked items

_____
_____
_____

Date of Last Physical Exam (Recommended within 24 months of event)_____

Physical Activities to be Limited or Restricted while at event

_____
_____
_____

SECTION VII – AUTHORIZATION

My child has permission to engage in all prescribed event activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the event staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.

Signature of Parent or Guardian X_____ Date_____