FAITH AND WORKS INCORPORATED

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 *a 501C3 nonprofit Corporation dedicated to creating programs and services that promote healing and cultural awareness. We are also empowering youth through the arts by coordinating activities that build a strong foundation of integrity, ethics, and good morals while fostering the gifts of individuals in communities nationwide.*

**CAMPER HEALTH HISTORY FORM**

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses.

Camper Parent/guardian with legal custody to be contacted in case of illness or injury: Relationship Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Camper: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Phones: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (If different from above) Street Address City State Zip Code Second parent/guardian or other emergency contact: Relationship Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Camper: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Phones: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Additional contact in event parent(s)/guardian(s) can not be reached: Relationship Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Camper: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Phones: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies: ≤ No known allergies. ≤ This camper is allergic to: ≤ Food ≤ Medicine ≤ The environment (insect stings, hay fever, etc.) ≤ Other (Please describe below what the camper is allergic to and the reaction seen.) Diet, Nutrition: ≤ This camper eats a regular diet. ≤ This camper eats a regular vegetarian diet. ≤ This camper is lactose intolerant. ≤ This camper is gluten intolerant. ≤ Other, please explain in space. Restrictions: ≤ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions. ≤ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. (Please describe below.) Medical Insurance Information: This camper is covered by family medical/hospital insurance ≤ Yes ≤ No Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable. Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company Phone Number (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a “need to know” basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child’s health record from providers who treat my child and these providers may talk with the program’s staff about my child’s health status. Signature of Custodial Relationship Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Camper: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance. Page 1/4 To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed. 1) Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy. 2) Send the original, signed FORM 1 to camp by the requested date. 3) Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child’s health-care provider for review and completion. 4) After it has been completed and signed by your child’s health-care provider, return FORM 2 to camp by the requested date. Camper Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (For Camp Use) Cabin or Group\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (For Camp Use) Session Code(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Middle Last Dates will attend camp: from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Month/Day/Year Month/Day/Year Camper Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Middle Last ≤ Male ≤ Female Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age on arrival at camp: \_\_\_\_\_\_\_\_ Month/Day/Year CAMPER HEALTH HISTORY FORM 1 Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses Immunization Dose 1 Month/Year Dose 2 Month/Year Dose 3 Month/Year Dose 4 Month/Year Dose 5 Month/Year Most Recent Dose Month/Year Diptheria, 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 (chicken pox) ≤ Had chicken pox Date: Meningococcal meningitis (MCV4) Tuberculosis (TB) test Date: ≤ Negative ≤ Positive If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized. Signature of Custodial Relationship Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Camper: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication: ≤ This camper will not take any daily medications while attending camp. ≤ This camper 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. Please review camp instructions about required packaging/containers. Many states require 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 time the camper will be at camp. Name of medication Date started Reason for taking it When it is given Amount or dose given How it is given ≤ Breakfast ≤ Lunch ≤ Dinner ≤ Bedtime ≤ Other time:\_\_\_\_\_\_\_\_\_\_\_\_\_ ≤ Breakfast ≤ Lunch ≤ Dinner ≤ Bedtime ≤ Other time:\_\_\_\_\_\_\_\_\_\_\_\_\_ ≤ Breakfast ≤ Lunch ≤ Dinner ≤ Bedtime ≤ Other time:\_\_\_\_\_\_\_\_\_\_\_\_\_ ≤ Breakfast ≤ Lunch ≤ Dinner ≤ Bedtime ≤ Other time:\_\_\_\_\_\_\_\_\_\_\_\_\_ The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. Cross out those the camper should not be given. Immunization History: Provide the month and year for each immunization. Starred (⎡) immunizations must include date to meet ACA Standard. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form. Camper Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Middle Last Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Month/Day/Year 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) Copyright 2014 by American Camping Association, Inc. Page 2/4 Rev.1/2014 LEE/EAW CAMPER HEALTH HISTORY FORM 1 Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses General Health History: Check “Yes” or “No” for each statement. Explain “Yes” answers below. Has/does the camper: Mental, Emotional, and Social Health: Check “Yes” or “No” for each statement. Has the camper: 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 camper’s life?............................................................................................................................................ ≤ Yes ≤ No (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) Please explain “Yes” answers in the space below, noting the number of the questions. The camp may contact you for additional information. Camper Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Middle Last Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Month/Day/Year Health-Care Providers: Name of camper’s primary doctor(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of dentist(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of orthodontist(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Copyright 2014 by American Camping Association, Inc. Page 3/4 Rev.1/2014 LEE/EAW 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. What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper’s health that you think important or that may affect the camper’s ability to fully participate in the camp program. Attach additional information if needed. Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records. CAMPER HEALTH HISTORY FORM 1 Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses Individual Health Record (For Camp Use Only) Camper Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Middle Last Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Month/Day/Year Copyright 2014 by American Camping Association, Inc. Page 4/4 Rev.1/2014 LEE/EAW Initial Screening Date/Time: \_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_\_\_\_ ≤ Screening has been conducted according to camp protocol and significant findings noted as follows: A. Any signs/symptoms of illness or injury upon arrival?........................ ≤ No ≤ Yes as noted below B. History of exposure to communicable disease?.................................. ≤ No ≤ Yes as noted below C. Additions or corrections to information on this health history?............ ≤ No ≤ Yes as noted below D. Medication given to health-care staff?.................................................. ≤ No ≤ Yes as noted below E. Any signs/symptoms of head lice?...................................................... ≤ No ≤ Yes as noted below Provider notes: (date/time/initial all entries) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_