NEWPORT JAZZ SUMMER CAMP
HEALTH HISTORY FORM

Parent/Guardian: Please complete both pages of this form and turn it in at Check-In with the Medical Exam and other forms. If your child requires special treatments, injections, is immune compromised, has mobility limitation (e.g. cast, crutches or wheelchair), no spleen, food allergies, dietary restrictions or other special issues, contact Peter Davis at 401-341-2297 or davisp@salve.edu. Some issues may require a doctor's note.

Child's Name: _____ Age: _____

Address: _____

Gender: _____ Birth Date: _____

Parent/Guardian Name: _____

Parent/Guardian Email: _____

Telephone Home: _____ Work: _____ Cell: _____

Name of another person to be contacted in case of emergency if you cannot be reached:

_____ Relationship to student: _____

Telephone Home: _____ Work: _____ Cell: _____

Parent/Guardian Health Ins. Company: _____Policy #: _____

NOTES TO PARENTS/GUARDIANS:

1. Please provide a copy of your insurance card.
2. If your child has had or has been exposed to a contagious disease or gets a serious cut, bruise, sprain, break, other injury or skin rash during the two weeks prior to coming to Newport Jazz Summer Camp, please contact Peter Davis at 401-341-2297 or davisp@salve.edu.
3. **Emergency Inhalers and Epi-pens/Benadryl** must include the doctor's written action plan. **These emergency medicines must be carried by the participant at all times. (Please pack a day pack).**
4. **All medications** must be in the original container and properly labeled and placed in a Ziplock bag with written instructions provided on this form. Medication must be managed and administered by the camper unless specific arrangements have been made with Peter Davis or in the case of an emergency.
5. I authorize the administration of Tylenol, Benadryl, or ibuprofen to my child if needed. Initial here:_____

If your child is bringing prescription medication, including epi-pen, please complete the following:

Medication: _____ Dosage/Time: _____ Reason: _____

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Medication: _____ Dosage/Time: _____ Reason: _____

MEDICAL BACKGROUND

If YES is checked, please give approximate dates, method of treatment and/or restrictions. If your child is under the care of a Social Worker, Psychologist, Behavioral Therapist, etc., please fill in specific information concerning your child's needs.

Bleeding Disorders _____Yes _____No _____
Epilepsy _____Yes _____No _____Requires a bottom bunk
Diabetes _____Yes _____No _____Requires a bottom bunk
Asthma _____Yes _____No Will bring inhaler?__Y ___N Will bring Nebulizer ___Y ___N
Kidney Trouble _____Yes _____No _____
Heart Trouble _____Yes _____No _____
Allergy Injections _____Yes _____No _____
Fainting _____Yes _____No _____Requires a bottom bunk
Bed Wetting _____Yes _____No _____Requires a bottom bunk
Sleep Walking _____Yes _____No _____Requires a bottom bunk
Compromised Immune Sys. _____Yes _____No _____
Spleen Removed _____Yes _____No _____
Emotional or Behavioral Iss. _____Yes _____No _____
Learning Disability _____Yes _____No _____
Requires an Aide at School _____Yes _____No _____
Other _____Yes _____No _____

Does your child have any allergic or other reactions to:(Please note reaction – must provide doctor's action plan)

Stings: Type _____ _____Yes _____No Carries Benadryl? ___Y ___N Carries Epi-Pen? ___Y ___N
Shellfish _____Yes _____No Carries Benadryl? ___Y ___N Carries Epi-Pen? ___Y ___N
Nuts _____Yes _____No Carries Benadryl? ___Y ___N Carries Epi-Pen? ___Y ___N
Raw Eggs _____Yes _____No Carries Benadryl? ___Y ___N Carries Epi-Pen? ___Y ___N
Eggs in All Forms _____Yes _____No Carries Benadryl? ___Y ___N Carries Epi-Pen? ___Y ___N
Soy _____Yes _____No Carries Benadryl? ___Y ___N Carries Epi-Pen? ___Y ___N
Celiac Disease _____Yes _____No Carries Benadryl? ___Y ___N Carries Epi-Pen? ___Y ___N
Gluten Allergy _____Yes _____No Carries Benadryl? ___Y ___N Carries Epi-Pen? ___Y ___N
Milk Protein _____Yes _____No Carries Benadryl? ___Y ___N Carries Epi-Pen? ___Y ___N
Lactose Intolerant _____Yes _____No Self Regulates? ___Y ___N _____
Other Allergies/Dietary Rest. _____Yes _____No Carries Benadryl? ___Y ___N Carries Epi-Pen? ___Y ___N
Vegetarian? _____Yes _____No _____
Is child under special treatment? _____Yes _____No _____
Restrictions at school or gym? _____Yes _____No _____
Has child had a tetanus booster? _____Yes _____No _____
Are immunizations up-to-date? _____Yes _____No _____
Traveled out of U.S. in last 3 mo. _____Yes _____No _____

Permission to secure treatment: In case of emergency, I give permission to have my child admitted to a hospital or other medical facility for medical treatment and assume responsibility for all medical expenses for my child. I understand that information provided on this form will be shared with those who will be directly caring for my child. In the event that an illness, injury, or any issue should arise in which my child is unable to continue the program, I authorize the campus management to dismiss my child early, in which case I will assume responsibility for arranging transportation. I authorize those listed on this form to sign out my child upon presentation of photo identification.

_____ _____

Parent/Guardian Signature (must sign) Date