

SCHOOL OF CINEMA & PERFORMING ARTS

375 GREENWICH STREET; NEW YORK, NY 10013

Health History and Examination Form (Due May 1, 2008):

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. Health history (first three pages) must be filled out by parents/guardians of minors or by adults themselves. Update required annually. Health exam must be completed by approved licensed medical personnel at least every two years.

Participant Information

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 address

(if different from above) _____
Street Address City State Zip

Business address _____ Phone _____
Street Address City State Zip

Second parent or guardian or emergency contact _____

Address _____ Phone _____
Street Address City State Zip

Business address _____ Phone _____
Street Address City State Zip

If not available in an emergency, notify _____

Relationship _____ Phone _____

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 # _____

***Please attach a photocopy of front and back of health insurance card to this form.**

Health History

The following information must be completed by the parent/ guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival at camp. Provide complete information so that the camp can be aware of your needs.

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.

_____	_____
_____	_____

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MAIL: SOCAPA; 375 Greenwich Street; New York, NY 10013

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.

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 _____

Med #3 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Attach additional pages for more medications.
Identify any medications taken during the school year that participant does/may not take during the summer: _____

Restrictions

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

General Questions [Explain “yes” answers below.]

Has/does the participant: Yes No	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/condition?	<input type="checkbox"/> <input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?.....	<input type="checkbox"/> <input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/> <input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/> <input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/> <input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<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 eye wear?	<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 bed-wetting?	<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 for which professional help was sought?	<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 any “yes” answers, noting the number of the questions (use additional sheet of paper if necessary).

Immunizations

Which of the following has the participant had?

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test

Date of last test _____

Result: Positive Negative

*** Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____	_____
or Mumps		_____	_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

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Parent or Guardian Signature Required

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.

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" 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 (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (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, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian _____

Printed Name _____ Date _____

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

Signature of participant (camper) _____ Date _____

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (Exam must be within 24 months of camp attendance. A new exam is not necessarily required for camp attendance.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions

Recommendations and Restrictions at Camp

Treatment to be continued at camp _____

Medications to be administered at camp (name, dosage, frequency) _____

Any medically-prescribed meal plan or dietary restrictions _____

Known allergies _____

Description of any limitation or restriction on camp activities _____

Additional information for health care staff at the camp _____

***Signature of Licensed Medical Personnel** _____

Printed _____ Title _____

Address _____

Phone _____ Date _____