Program Name: ___________________________ Program Date(s):_____________

Residential Health Form

PARTICIPANT INFORMATION

Participant Name: ____
First Middle Last

Sex__________ Birth Date ____________ Age on arrival at program: _____
Month/Day/Year

Date of last Physical: _______________________________

EMERGENCY CONTACT INFORMATION

Parent/Legal Guardian with legal custody to be contacted in case of illness or injury:

Name: _____________________________________ Relationship to Participant: ____________

Home Address: ____

Preferred Phones: (_____)_____________ (_____)_____________ Email ______________

Please list two emergency contacts. Parent/Legal Guardian agrees that the Program has permission to contact the named emergency contacts in the event of an emergency or other appropriate circumstances and consents to the Participant being released to the custody and care of the emergency contact (if deemed necessary or appropriate by the Program) when Parent/Legal Guardian cannot be reached.

____
Emergency Contact # 1 Name Home Phone Work Phone Cell Phone Relation

____
Emergency Contact # 2 Name Home Phone Work Phone Cell Phone Relation

INSURANCE INFORMATION

Participant is required to be covered by U.S.-based medical insurance.

Policy Holder's (P.H.) Name: ___________________________ P.H.'s Date of Birth: ________________

P.H.'s Relation to Participant: ________________________ P.H.'s Address:___________________________

Insurance Company: _____________________________ Insurance Phone Number: (_____)_____________

Policy #: ____________________________________ Group #: _______________________

HEALTH HISTORY

Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the Participant:

1. Ever been hospitalized? .... Yes No
2. Ever had surgery? .... Yes No
3. Have recurrent/chronic illnesses? .... Yes No
4. Had a recent infectious disease? ....………............................ Yes No

5. Had a recent injury? ....………....... .... Yes No
6. Had asthma/wheezing/shortness of breath?........... .... Yes No
7. Have diabetes? ....……………............................ Yes No
8. Had seizures? .... Yes No
9. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder? …………………………………… Yes No
10. Ever been treated for emotional or behavioral difficulties or an eating disorder? ………………………………………………. Yes No
11. During the past 12 months, seen a professional to address mental/emotional health concerns? …………………………….. Yes No
12. Had a significant life event that continues to affect the Participant's life? *(I.e. History of abuse, death of a loved one, family change, foster care, new sibling, survived a disaster, others)* ….. Yes No
13. Had headaches?... Yes No
14. Wear glasses, contacts, or protective eyewear? .... Yes No
15. Experienced fainting or dizziness?... Yes No
16. Passed out/had chest pain during exercise?.................................. Yes No
17. Had mononucleosis ("mono") during the past 12 months?........... Yes No
18. If female, have problems with periods/menstruation?. .... Yes No
19. Have problems with falling asleep/sleepwalking?........................ Yes No
20. Ever had back/joint problems?….. Yes No
21. Have a history of bedwetting?…... Yes No
22. Have problems with diarrhea/constipation?….............................. Yes No
23. Have any skin problems?… .... Yes No
24. 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.

____

____

The Participant is undergoing treatment at this time for the following conditions:
(describe below) ☐ None.

____

____

ALLERGIES

No known allergies
To foods *(list)*:
To medications *(list)*:
To the environment *(insect stings, hay fever, etc.– list)*:
Other allergies *(list)*:
Dietary restrictions *(list)*:

Describe previous reactions

____

____

Explain/describe if Participant has a need for an EpiPen or Epinephrine

____

____

MEDICATION INFORMATION
☐ No daily medications.
☐ Will take the following prescribed medication(s) while at the Program.
Any special storage requirements for the medications are noted below.

Medication Name ___________________________ Dose: __________________________

Frequency: ____________________________________ Reason: _________________________

Medication Name ___________________________ Dose: _____________________

Frequency: ____________________________________ Reason: _________________________

____

Other treatments/therapies to be continued during the Program**:**
(describe below) ☐ None needed.

____

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You must attach authorization from a licensed health care provider (ie, a prescription) for all medications Participant will bring to the Program. All medications must be brought to the Program in their original packaging, and must be checked in with program staff on arrival day to be securely stored. Participants may (and are encouraged to) keep with them urgent-need medications such as inhalers, epinephrine, insulin, and glucagon devices.

OTC MEDICATION AUTHORIZATION
The following non-prescription drugs may be stocked by the Program and may be used on an as-needed basis to manage illness and injury. Cross out those this Participant should NOT be given.

Acetaminophen (Tylenol)	Bismuth subsalicylate (e.g., Pepto-Bismol)
Ibuprofen (e.g., Advil, Motrin)	Laxatives for constipation (e.g., Ex-Lax)
Guaifenesin	Hydrocortisone 1% cream
Diphenhydramine (e.g., Benadryl)	Topical antibiotic cream
Generic cough drops	Aloe
Lice shampoo or scabies cream	Antifungal cream
Antacids (e.g., Tums)	Loperamide (e.g., Imodium)
Calamine lotion	

OTHER INFORMATION
Please provide in the space below any additional information about the Participant's health that you think important or that may affect the Participant's ability to fully participate in the program. Attach additional information if needed.

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IMMUNIZATION HISTORY
Please provide the following immunization history information. **You must attach a provider record verifying Participant's immunization history.**

You must also complete the separate Covid-19 Vaccination Verification Form.

REQUIRED IMMUNIZATIONS

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
DTaP/DTP/Td (All Participants must submit documentation of 3 doses of tetanus. One MUST be a Tdap. One must be given in the last 10 years)				
Tdap				
MMR (Measles, Mumps, Rubella) 2 MMR vaccines required on or after first birthday **OR** positive titers (lab reports must be attached) **OR**				
Measles (single antigen 2 required on or after first birthday)				
Mumps (single antigen 2 required on or after first birthday)				
Rubella (single antigen 1 required on or after first birthday)				
Hepatitis B (The state of NC does not accept titers for this requirement. Designate vaccine type and list dates below.)				
Engerix-B (3 doses required) OR				
Heplisav-B (2 doses required)				
Meningococcal ACWY (Required after age 12. Booster required after age 16)				
Varicella (chickenpox)				
Varicella vaccine (2 doses required) OR				
Varicella IgG positive titer (lab report must be attached)				
Polio (3 doses required for Participants under the age of 18)				

FITNESS TO PARTICIPATE
I certify that the above information is complete and accurate. I have reviewed and understand the program description and activities of the program and believe that Participant is physically and emotionally fit to participate in the Program without restrictions or adaptations, except as noted below:

____

____

Yes No