Participant History and Physical 2019

26001 Heinz Road, Willow River, MN 55795
Phone: 888.545.6658 Fax: 218-372-8010

Pages 2-4 must be completed by participant's physician.

All participants must have a physical within a year of the start of their session.
All participants need to submit updated insurance and medication information.

Parent/Guardian/Participant if over 18 must complete this page:

Participant's Name : _____ **Date of Birth :** _____

I request and authorize: _____ (Health Care Provider) to release healthcare information of the participant named above to : One Heartland, Inc., 26001 Heinz Road, Willow River, MN 55795. This request and authorization applies to this medical form.

Signed: _____ **Printed Name:** _____ **Relationship:** _____

Insurance Information:
Please fill out all that apply AND attach a copy of the participant's insurance card:

Name of Insurance Company #1: _____ **Insurance Phone:** _____

Name of Policy Holder: _____

Identification #: _____ **Member #:** _____ **Group #:** _____

Name of Insurance Company #2: _____ **Insurance Phone:** _____

Name of Policy Holder: _____

Identification #: _____ **Member #:** _____ **Group #:** _____

Medicaid State and Number: _____

Medication Information:
Please send all medications, tube feedings, IV/catheter dressings, insulin, inhalers, blood glucose monitor and any other supplies necessary while at camp. Please send all medications in their ORIGINAL PRESCRIPTION CONTAINERS. The medical staff will store and administer medications as directed by [er. Licensed personnel will supervise the administration of all medication.

Please list all medication(s) the participant is currently taking. Also, please indicate if a medication is taken with food, specific beverage, before or after a meal, etc. Instructions on any unique ways this participant takes his/her medication will be very helpful in maintaining their dosing schedule (use additional paper if necessary). If the participant is not taking medications please write "NONE".

Medication Name:	Dose:	Times taken each day:	Notes:

Special directions/considerations/allergies/dietary needs: _____

_____

Physician must complete the remainder of this form:

Participant's Name: _____ **Date of Most Recent Physical Exam**: _____

Date of Birth: _____ Gender: _____ Height: _____ Weight: _____

Temp.: _____ BP: _____ Pulse: _____

PHYSICIAN INFORMATION

Name: _____ Office phone: _____

Address: _____ Office fax: _____

_____ Emergency #: _____

_____ (on-call contact) _____

ALLERGIES

Allergies or adverse reaction to medications: Yes ___ No ___ If yes, please list with treatment plan: _____

_____

Allergies or adverse side effects to foods: Yes _____ No ___ If yes, please list with treatment plan: _____

_____

Allergies or adverse side effects to environmental: Yes _____ No ___ If yes, please list with treatment plan: _____

_____

Please complete the following Health History information **(MUST BE COMPLETED BY PHYSICIAN):**

Asthma:	Yes ____ No ____	High Blood Pressure	Yes ____ No ____
Bed Wetting:	Yes ____ No ____	High Cholesterol	Yes ____ No ____
Bleeding Disorders:	Yes ____ No ____	HIV/AIDS	Yes ____ No ____
Chronic Diarrhea:	Yes ____ No ____	Heart defect/disease:	Yes ____ No ____
Chicken pox &/or shingles:	Yes ____ No ____	Liver Disease	Yes ____ No ____
Convulsions/seizures:	Yes ____ No ____	Measles:	Yes ____ No ____
Cryptosporidium:	Yes ____ No ____	Mumps:	Yes ____ No ____
Cystic Fibrosis	Yes ____ No ____	Night Sweats	Yes ____ No ____
Diabetes type 1:	Yes ____ No ____	Persistent Cough:	Yes ____ No ____
Diabetes type 2:	Yes ____ No ____	Pneumonia:	Yes ____ No ____
Eating Disorders:	Yes ____ No ____	Thrush:	Yes ____ No ____
Frequent ear infections:	Yes ____ No ____	Thyroid Disease	Yes ____ No ____
Herpes Virus:	Yes ____ No ____	Weight loss	Yes ____ No ____

Surgery hx/dates _____

_____

Hospitalizations within the past year (date, diagnosis, outcome): _____

_____

Other significant diagnosis or illnesses: _____

_____

Participant's Name : _____

Please list any physical disability, pertinent physical findings or *attach a recent H & P:*

_____

_____

Does child require the use of: Wheelchair ____ Walker ____ Crutches ____ Brace/Splint____ Other _____

Special considerations/instructions:_____

Restrictions (if any):_____

Laboratory Data (for participant with HIV/AIDS only)

CBC

DATE OF TEST	_____
WBC (4.5- 11.0)	_____
RBC (3.9- 5.03)	_____
HCT (34.9-44.5)	_____
Hgb (12-15.5)	_____
Plt (140-440)	_____

HIV Labs

DATE OF TEST	_____
T-Cell count	_____
Viral Load	_____

Do labs need to be drawn while participant is at camp?

no _____

yes _____

if yes, please list order

_____

_____

Participant with diabetes only

Has type 2 diabetes ____ yes _____ no

Has type 1 diabetes ____ yes _____ no

Monitors blood glucose levels ____ yes _____ no

If yes, what are the blood glucose target ranges: _____---_____ pre-meal _____ bedtime

Is on insulin ____ yes _____ no

If yes, indicate the last prescribed insulin doses:

Rapid acting insulin (type)_____

Dose before meals (may list as units per grams of carbohydrates):

_____ Breakfast _____ Lunch _____ Dinner _____ Snacks

Correction scale dosage: _____ units per _____ mg/dl when BG > _____

Long acting insulin (type) _____ Time this is given _____

If on insulin pump, please list brand and model: _____

Glucagon dosage: _____ SQ/IM

Other medication taken for diabetes, please list medication and dosage: _____

_____

Do you have any specific concerns about the management of this participant's health care or behavior at camp?

_____ yes _____ no

If yes, please explain:_____

_____

Participant's Name : _____

IMMUNIZATION HISTORY - All immunization information must be current to date of form completion.		
VACCINES	PRIMARY SERIES	BOOSTER
DPT		
Measles, Mumps, Rubella		
Polio		
Tetanus (specify type)		
Pneumococcal Vaccine		
H. Flu Vaccine (HIB)		
Hepatitis A		
Hepatitis B		
Varicella Vaccine		
Influenza		

Please list any physical disability, illness, pertinent physical findings or attach a recent H & P:

_____

_____

Please list any other medications (and dosages) camper takes:

_____

Physician Verification

I have examined the above named person herein described and have reviewed the health history. It is my opinion that this person:

_____ **is** physically able to travel to camp and engage in camp activities.
_____ **is not** physically able to travel to camp, or engage in camp activities (please explain below)
_____ is able to travel to camp, and engage in camp activities, **but has restrictions as follows:**

The participant is able to participate in swimming pool activities when offered: YES NO

_____

_____

Signature of Physician: _____ **Date:** _____