



Participant History and Physical 2018

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

HIV Labs

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

DATE OF TEST _____

DATE OF TEST _____

no _____

WBC (4.5- 11.0) _____

T-Cell count _____

yes _____

RBC (3.9- 5.03) _____

Viral Load _____

if yes, please list order

HCT (34.9-44.5) _____

Hgb (12-15.5) _____

Plt (140-440) _____

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: _____