oneheartland
Where belonging begins.

Participant History and Physical 2016

2101 Hennepin Ave. S., Suite 200, Minneapolis, MN 55405
Phone: 888.216.2028 Fax: 612.824.6303

This 3 page form must be completed by participant's physician.

All participants must have a physical and TB test within a year of the start of their session.
All participants need an updated "Insurance and Medication Information" form.

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

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., 2101 Hennepin Ave . S, Suite 200, Minneapolis MN 55405. This request and authorization applies to this medical form.

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

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: _____ **ALLERGIES**: _____

PHYSICIAN INFORMATION

Name: _____ Office phone: _____

Address: _____ Office fax: _____

_____ Emergency #: _____

_____ (on-call contact) _____

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

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

Chicken pox &/or shingles: Yes ____ No ____ Has participant received Varicella Vaccine? Yes ____ No ____ if yes, date _____

Is participant known to be Varicella immune? Yes ____ No ____ Antibody screen done? Yes ____ No ____ if yes, date _____
Has participant received VZIG? Yes ____ No ____ if yes, date _____
Has participant been treated for head lice in the past 6 months? Yes _____ No _____

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:_____

_____

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		

Tuberculosis Testing (MUST BE COMPLETED BY PHYSICIAN)

TB testing information is ***required*** for the participant's participation. A TB test result must be documented within the past year. A new test is ***required*** if your participant's last TB test is not within a year of the start of their session.

TB skin test (Mantoux): Date placed: _____ Date read: _____ Please circle: Positive Negative

TB blood test (Q-Gold or T-Spot): Date: _____ Please circle: Positive Negative

Chest X-ray (if applicable) Date: _____ Please circle: Positive Negative

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

Influenza Vaccination Record

Although we do not require an Influenza vaccination, One Heartland strongly recommends that everyone take the opportunity to prevent the spread of this virus.

Did the participant receive the Influenza vaccination? _____ Date: _____

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:** _____