BERKSHIRE MUSEUM

FOR OFFICE USE ONLY

YEAR: ________

SESSION/GROUP: ________

NAME: ________

HEALTH HISTORY FORM FOR YOUTH ATTENDING SUMMER CAMPS

The information on this form is not part of the camp member or staff acceptance process but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to museum health personnel upon participant's arrival at the program. Please provide complete information so that we can be aware of your needs.

FILL OUT THIS FORM IN FULL AND RETURN BEFORE THE START OF THE PROGRAM VIA EMAIL OR MAIL.

Via email to:
programs@berkshiremuseum.org

Via mail to:
Berkshire Museum
Summer Camps
39 South Street
Pittsfield, MA 01201

Name:______________________________Birth Date: ______________ Age at start of program: ______
Home Address: ____
Custodial Parent/Guardian:____________________________________ Phone:____________________
Home Address:____

Second Parent/Guardian or Emergency Contact:____
Address:____Phone:______________________

If not available in an emergency, notify:____
Phone:___________________________ Relationship to Camper:________________________
Address:____

INSURANCE INFORMATION

Is the camp participant covered by family medical/hospital insurance?
☐ Yes ☐ No

If so, indicate carrier or plan name:_______________________________
Group #______________________________________

A photocopy of front and back of health insurance card must be attached to this form.

IMPORTANT: These boxes must be complete for attendance.*

Parent/Guardian Authorizations: This healthy history is correct and complete as far as I know, and the person herein described has permission to engage in all program activities except as noted. I hereby give permission to the Berkshire Museum to provide routine health care, administer pr scribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the museum to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician or medical facility selected by the museum to secure and administer treatment, including hospitalizations for the person named above. This completed form may be photocopied for trips outside of the museum building.

Signature of parent /guardian:______________________________
Printed Name:____
Date:___________

I also understand and agree to abide by any restrictions placed on my participation in program activities.
Signature of Camp Attendee:_________________________________

** If for religious reasons you cannot sign this, contact Berkshire Museum for a legal waiver which must be signed for attendance.*

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ALLERGIES:

*List all known. Describe reaction and management of the reaction.***

Medication Allergies (list)

____

Food Allergies (list)

____

Other Allergies (list) — include insect stings, hayfever, asthma, animal dander, etc.

____

*** If allergies are life-threatening, please have your physician provide a medical allergy action plan.*

MEDICATIONS BEING TAKEN

Will any medications need to be taken by this child during camp time?

☐ **YES** ☐ **NO**

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely.

Med #1:______________________ Dosage:____________

Specific Times Taken Each Day:______________________

Reason for taking:______________________

Med #2:______________________ Dosage:____________

Specific Times Taken Each Day: ______________________

Reason for taking: ______________________

Attach additional pages for more medications.

RESTRICTIONS

(the following restrictions apply to this individual)

DOES NOT EAT:

☐ Red Meat ☐ Pork ☐ Dairy ☐ Poultry ☐ Seafood ☐ Eggs ☐ Other:______________

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

____

____

____

____

Please list any addtional information you feel may be important regarding medication and allergies:

____

____

____

____

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GENERAL QUESTIONS

EXPLAIN "YES" ANSWERS BELOW.

HAS/DOES THE PARTICIPANT:

1. HAD ANY RECENT INJURY, ILLNESS, OR INFECTIOUS DISEASE?
2. HAVE A CHRONIC OR RECURRING ILLNESS/CONDITION?
3. EVER BEEN HOSPITALIZED?
4. EVER HAD SURGERY?
5. HAVE FREQUENT HEADACHES?
6. EVER HAD A HEAD INJURY?
7. EVER BEEN KNOCKED UNCONSCIOUS?
8. WEAR GLASSES, CONTACTS, OR PROTECTIVE EYEWEAR?
9. EVER HAD FREQUENT EAR INFECTIONS?
10. EVER PASSED OUT DURING OR AFTER EXERCISE?
11. EVER BEEN DIZZY DURING OR AFTER EXERCISE?
12. EVER HAD SEIZURES?
13. EVER HAD CHEST PAIN DURING OR AFTER EXERCISE?
14. EVER HAD HIGH BLOOD PRESSURE?
15. EVER BEEN DIAGNOSED WITH A HEART MURMUR?
16. EVER HAD BACK PROBLEMS?
17. EVER HAD PROBLEMS WITH JOINTS (E.G., KNEES, ANKLES)
18. HAVE AN ORTHODONTIC APPLIANCE BEING BROUGHT TO THE PROGRAM?
19. HAVE ANY SKIN PROBLEMS (E.G., ITCHING, RASH, ACNE)?
20. HAVE DIABETES?
21. HAVE ASTHMA?
22. HAD MONONUCLEOSIS IN THE PAST 12 MONTHS?
23. HAVE BATHROOMING/BOWEL DIFFICULTIES?

PLEASE EXPLAIN ANY "YES" ANSWERS, NOTING THE NUMBER OF THE QUESTIONS.

____

____

____

IMMUNIZATIONS

Which of the following vaccinations has the participant had?

☐ Measles

☐ Chicken Pox

☐ German Measles

☐ Mumps

☐ Hepatitis A

☐ Hepatitis B

☐ TB Montoux Text

Date of last test: __________

Result: ☐ Positive ☐ Negative

Please attached a copy of vaccination record.
If you do not have a copy of the record – fill out the table below.

Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	______	______	______	______	______	______
TD (Tetanus/Diptheria)	______	______	______	______	______	______
Tetanus	______	______	______	______	______	______
Polio	______	______	______	______		
MMR	______	______				
or Measles	______	______				
or Mumps	______	______				
or Rubella	______	______				
Haemophilus						
Influenza B	______	______				
Hepatitis B	______	______	______			
Varicella (Chicken Pox)	______	______				

Family physician: ______________________ Phone: ______________

Address: ______________________________

Family dentist/orthodontist: ______________________ Phone: ______________

Address: ______________________________

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USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION ABOUT THE CAMPER'S BEHAVIOR AND PHYSICAL, EMOTIONAL, OR MENTAL HEALTH ABOUT WHICH PROGRAM STAFF SHOULD BE AWARE.