

2011 Streamline Swim Clinic

Physical Examination/Medical History Form

Last Name: _____ First Name: _____

DOB: _____

Home Address: _____

City: _____ State: _____ Zip code: _____

Parent/Guardian 1: _____ Relation: _____

Day Phone: (_____) _____ Cell: (_____) _____

Parent/Guardian 2: _____ Relation: _____

Day Phone: (_____) _____ Cell: (_____) _____

Health History

Please fill in dates where appropriate

[] **Please Check here if your child has allergies to Latex.** If your child does have allergies we will provide them with a non-latex swim cap.

Illness

Frequent Ear Infections _____

Heart Defect/Disease _____

Convulsions _____

Diabetes _____

Bleeding/Clotting Disorders _____

***Allergies

Hay Fever _____

Ivy Poisoning _____

*Insect Stings _____

Medicine _____

Foods _____

Disease

Chicken pox _____

Measles _____

German Measles _____

Mumps _____

**Asthma _____ *What Insects _____

** Please describe care necessary to handle asthma (i.e. inhaler) _____

***If Epi-Pen is required to handle allergic reaction, family must supply one

Operations or serious injuries (with dates) _____

Chronic or recurring illness _____

Any specific activities to be restricted: _____

Name of Campers Dentist: _____

Name of Campers Doctor: _____

Name of Medical Insurance Carrier: _____

Address: _____ Phone: _____

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Immunization History & Dates

DPT 1. _____
2. _____
3. _____

Polio 1. _____
2. _____
3. _____

MMR (combined)
1. _____
2. _____

History of Chicken Pox HIB

Yes _____
Date _____
No _____

1. _____
2. _____
3. _____
4. _____

Hepatitis B Series
(children born after 1/1/93)
1. _____
2. _____
3. _____

Medical Examination

- To be filled by a licensed physician
- This examination should be performed within one calendar year of arrival at the Streamline Swim Clinic.
- Examination for some other purpose within this period is acceptable.

Code: V-Satisfactory
X-Not Satisfactory (explain)
O-Not Satisfactory

Ht. _____ Wt. _____ Blood Pressure _____ Urinalysis _____
Eyes _____ Lungs _____ Allergy _____
Please describe degree of reaction: _____

Glasses _____ Contacts _____ Throat _____
Ears _____ Nose _____ Heart _____
Abdomen _____ Hernia _____ Posture _____
Extremities _____ Skin _____ Genitalia _____
Special Diet _____

Current Medications _____

****Streamline Swim Clinic and Health Supervisor are NOT authorized to administer medication to any player without written consent by the parent***

I have examined the person described herein and have reviewed the health history. It is my opinion that this person is physically able to engage in program activities as noted above.

Examining Physician signature: _____ Date: _____
Please Print Physician's Name: _____
Address: _____ Phone: _____

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Health Care Policy Guidelines

Mandated by Massachusetts State Law 105 CMR 430.159 (B), the following appropriate care will be administered to participants by the medical staff:

Mildly ill swimmers will be evaluated by the Health Supervisor in a safe location. Treatment will be administered per standing order and the Health Care Consultant will be notified if necessary. If condition persists or worsens, appropriate care will be administered and the parent/guardian will be notified.

Emergency Care: The Health Supervisor will make the decision as to what emergency care would be needed. He will evaluate need for activation E.M.S. system. For emergency injuries, 911 will be contacted for ambulance transport and the parents will be notified.

I have read the Health Care Policy Guidelines stated above

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ Date: _____

Parent Guardian Authorization

Must be signed for child to participate in camp

This Health History is correct so far as I know, and the child described herein has permission to engage in all prescribed program activities except as noted by the examining physician and me. I hereby, authorize the staff of Streamline Swim Clinic to provide care that includes routine diagnostic procedures (i.e. x-rays, blood and urine test) and medical treatment to my minor camper. I understand that the consent and authorization herein granted does not include major surgical procedures and are valid only during camp. I understand the Streamline Swim Clinic, Dana Hall and staff associated with the camp may not be held responsible for any accident or incident during the duration of camp. All participants must have their own primary medical insurance. Any medical claims will be the primary responsibility of parent or guardian's medical coverage on an as needed basis.

Parent/Guardian Name (Please Print): _____

Parent Guardian Signature: _____ Date: _____

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Authorization to Administer Medication

Streamline Swim Clinic and the Health Supervisor will not administer non-authorized medications

Name of Camper: _____ Age: _____

Parent/Guardian: _____

Home Phone: _____ Business Phone: _____

Emergency Phone: _____

Food/Drug Allergies: _____

Diagnosis (at Parent's Discretion): _____

Name of Licensed Prescriber: _____

Business Phone: _____

Name of Medication: _____ Dose Given: _____

Route of Administration: _____ Frequency: _____

Date Ordered: _____ Duration of Order: _____

Quantity Received: _____ Expiration Date of Medications Received: _____

Special Storage Requirements: _____

Specific Instructions: _____

Specific Precautions: _____

Possible Side Effects/Adverse Reactions: _____

Other Medications: _____

Location where medication administration will occur: _____

According to the Department of Health 430.160, "Medication prescribed for campers shall be kept in the original containers bearing the pharmacy label, which shows the date filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, direction for use and cautionary medications statement, if any, contained in such prescription by law, and if tablet or capsules, the number in the container. All over the counter medication for campers shall be kept in the original containers containing the original label, which shall include directions for use. When no longer needed, medications shall be returned to the parent or guardian whenever possible. If the medication cannot be returned, it shall be destroyed."

The directions given on this form regarding the administration of my son/daughters medication is accurate. I give authorization for the medical staff at the Streamline Swim Clinic to administer the medication on this form to my child.

(Name of Camper)

(Parent/Guardian Name- Print)

(Parent/Guardian Signature)

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Pick-Up Authorization

Mandated by Massachusetts State Law 105 CMR 430.159 (B), please provide a list of the individuals who will be authorized to pick-up the named swimmer. No swimmer will be released to an individual who is not listed. In case a change is needed, a phone call must be made to Ethan Treat at 617-669-1392 by 12pm on that day.

Camper's Name: _____

Camper's Name: _____

Parent/Guardian Signature: _____ Date: _____

The following people are authorized to pick up my child from Streamline:

1. _____ 2. _____

3. _____ 4. _____

The following people are not authorized to pick up my child from Streamline:

1. _____ 2. _____

3. _____ 4. _____