STAGEDOOR MANOR PERFORMING ARTS TRAINING CENTER
Health History and Physician's Examination

NAME:_____ Gender: Choose **Birthdate:** Age: _____

ADDRESS: **CITY:** **Zip/Post Code:**

COUNTRY: PHONES *Home*: *Cell*:

_

Emergency Contact 1: _____ Relationship: _____

Address: _____

Phones Home _____ Cell _____ Work _____

Emergency Contact 2: _____ Relationship: _____

Address: _____

Phones Home: _____ Cell _____ Work _____

Insurance Information: fill out information below. A photocopy of the front and back of your health insurance card must be attached.

Policy Holder:_____ Insurance Carrier:_____ Policy #: _____

Carrier Address: _____ Carrier Phone Number: _____

Primary Care Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Other Physician: _____ Phone: _____

This Health Form is correct and complete as far as I know. I understand and agree to abide by any restrictions placed on my participation in camp activities by the examining medical personnel.

I hereby give permission for me to receive necessary medical care while at camp, including tests and medications. I give permission for camp to release any records required for necessary care and/or for insurance purposes. In case I cannot respond in an emergency, I hereby give permission to the physicians and hospitals selected by camp to administer treatment, including hospitalization.

Signature of Staff Member: _____Date: _____

HEALTH HISTORY:

Allergies: Medications ○ No ○ Yes List: _____

Food ○ No ○ Yes List: _____

Bee Sting ○ No ○ Yes List: _____

Other ○ No ○ Yes List: _____

Are any specific medications required to address any of these allergic reactions? If yes, please explain and provide the medication with clearly marked instructions. _____

_____

Are there any dietary restrictions or issues? Please explain: _____

IMMUNIZATION HISTORY: Please record dates of basic immunizations

Immunization	*Date Initial series &/or booster*	*Immunization*	*Date Initial series &/or booster*	*Immunization*	*Date Initial series &/or booster*
DTP		MMR		Varicella	
TD		Or Measles		Meningococcal	
Tetanus		Or Mumps		TB test date:	
Polio		Or Rubella		TB test results: ☐ positive ☐ negative	
H. Influenza B (HIB)		Hepatitis A			
Influenza/H1N1		Hepatitis B		Other:	

COVID-19 VACCINE:

Vaccine #1 date: _____
Manufacturer:_____

Vaccine #2 date: _____
Manufacturer:_____

Booster Date:_____
Manufacturer:_____

PRESCRIPTION MEDICATIONS (Please complete with current regimen for both daily and PRN medications.)

Drug	Route	Dosage	Frequency	Indication for Use

HEALTH HISTORY: Please indicate YES or NO and give approximate dates

DISEASE	YES	NO	DATE	DISEASE	YES	NO	DATE	DISEASE	YES	NO	DATE
Asthma				Fainting				Immune Disorder			
Blood Disorders				Headache/Migraine				Joint Disorders			
Diabetes				Heart Condition				Kidney Disorders			
Depression				Hepatitis A – B – C				Seizures/Epilepsy			
Eating Disorders				Hypertension				Spine/Back			

Please explain any YES answer: _____

_____

Chronic or recurring illness not mentioned above: _____

_____

Operations or serious illnesses? _____

_____

Recent illness, injury, or infectious disease?_____

_____

Any history of emotional or mental disturbances? ☐Yes ☐No If yes, please explain:_____

_____

(Female) Is menstrual history normal? ☐Yes ☐No...If no, are special considerations needed?_____

TO THE PHYSICIAN: This person will serve up to four months in the USA as a leader in a summer theater camp for children or as support staff in the kitchen, office, or maintenance department. Your careful examination and written recommendations will encourage physical wellness and safe participation in camp activities.

PHYSICIAN'S EXAMINATION: Weight: _____ Height: _____ BP: _____

Allergies (please specify allergen and reaction): _____

_____

EXAM: Please indicate whether the following are satisfactory (S), unsatisfactory (U) or not examined (NE):

Eyes	Lungs	Skin
Ears	Heart	Extremities
Nose	Hernia	Posture (Spine)
Throat	Abdomen	

General appraisal: _____

Any restrictions on: Swimming ____ Tennis _____ Aerobics _____ Strenuous Activities _____ Other: _____

Additional information for the health care staff at the camp: _____

_____

FOR PHYSICIAN: I have examined this person, have reviewed the health history and prescribed medications as indicated. It is my opinion that this person is physically able to engage in camp activities, except as noted above.

_____

Licensed Provider's Signature Printed Name of Provider

_____

Address Phone Date of Exam