August 2019

Health Care Provider Form (Form 2)

To Parents/Legal Guardians: Complete this section and give this form, along with a copy of the completed and signed MEDICAL HISTORY FORM (FORM 1), to your child's health care provider for review.

Participant Name:_____
Participant Address: _____
Participant Date of Birth: _____
Parent/Legal Guardian phone numbers: (____) _____ and (____)_____

Parents/Legal Guardians: **STOP HERE**. The remainder of this form is to be completed by medical personnel.

To Medical Personnel: Please review the MEDICAL HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: □ Yes □No (If "No," date of last physical:_____)
Month/Day/Year

Weight:_____ lbs. Height: ___ft. ___in. Blood Pressure___/____

Allergies:
☐ No known allergies
□ To foods ***(list)***:
□ To medications ***(list)***:
□ To the environment ***(insect stings, hay fever, etc.– list)***:
□ Other allergies ***(list)***:
□ Dietary restrictions ***(list)***:

Describe previous reactions

_____

Explain/describe if Participant has a need for an EpiPen or Epinephrine

_____

Immunization History

Please provide the following immunization history information. An attached provider form with an official stamp and an authorized signature will be accepted.

SECTION A: REQUIRED IMMUNIZATIONS

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
DTaP/DTP/Td (All Participants must submit documentation of 3 doses of tetanus. One MUST be a Tdap. One must be given in the last 10 years)				
Tdap				
MMR (Measles, Mumps, Rubella) 2 MMR vaccines required on or after first birthday **OR** positive titers (lab reports must be attache**d)** **OR**				
Measles (single antigen 2 required on or after first birthday)				
Mumps (single antigen 2 required on or after first birthday)				
Rubella (single antigen 1 required on or after first birthday)				
Hepatitis B (The state of NC does not accept titers for this requirement. Designate vaccine type and list dates below.)				
Engerix-B (3 doses required) OR				
Heplisav-B (2 doses required)				
Meningococcal ACWY (Required after age 12. Booster required after age 16)				
Varicella (chickenpox)				
Varicella vaccine (2 doses required) OR				
Varicella IgG positive titer (lab report must be attached)				
Polio (3 doses required for Participants under the age of 18)				

SECTION B: ADDITIONAL IMMUNIZATIONS

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Meningococcal B				
Bexsero OR				
Trumenba				
Gardasil				
Twinrix (Hepatitis A/ B combination)				
Hepatitis A				
Varicella (Chickenpox)				
Ixiaro (Japanese Encepha litis)				
Typhoid (specify vaccine)		Oral	IM	
Yellow Fever				
Rabies				

Medications

☐ No daily medications.
☐ Will take the following prescribed medication(s) while at the Program.
Any special storage requirements for the medications are noted below.

Medication Name _____ Dose: _____

Frequency: _____ Reason: _____

Medication Name _____ Dose: _____

Frequency: _____ Reason: _____

_____

_____

Other treatments/therapies to be continued during the Program:
(describe below) ☐ None needed.

_____

_____

OTC Medications
The following non-prescription drugs may be stocked by the Program and may be used on an as-needed basis to manage illness and injury. Cross out those this Participant should NOT be given.

Acetaminophen (Tylenol) Ibuprofen (e.g., Advil, Motrin) Guaifenesin Diphenhydramine (e.g., Benadryl) Generic cough drops Lice shampoo or scabies cream Antacids (e.g., Tums) Calamine lotion	Bismuth subsalicylate (e.g., Pepto-Bismol) Laxatives for constipation (e.g., Ex-Lax) Hydrocortisone 1% cream Topical antibiotic cream Aloe Antifungal cream Loperamide (e.g., Imodium)

The Participant is undergoing treatment at this time for the following conditions:
(describe below) ☐ None.

_____

_____

Do you feel that the Participant will require limitations or restrictions to activity while at the Program?
☐ No ☐ Yes

If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

_____

_____

I have reviewed the MEDICAL HISTORY FORM (FORM 1) and have completed this HEALTH CARE PROVIDER FORM (FORM 2). It is my opinion that the child is physically and emotionally fit to participate in the Program (except as noted above).

Name of Licensed Provider (please print): _____

Signature: _____

Title: _____

Office Address _____
Street

City_____ State _____ Zip Code _____

Telephone: (____)_____ Date: _____