

MEDICAL HISTORY AND EXAMINATION FORM

FORMS MUST BE RETURNED NO LATER THAN JUNE 1, 2010

The submission of health forms is required for attendance at our summer program. You should complete the Medical History (items 1 to 10) prior to your medical examination. The Physical Examination Form (items 1 to 14) must be completed and signed by a qualified, licensed physician. The physician's office may also submit all required information on their own form. All students must submit health insurance information.

If your child has had a physical examination within 1 year of the ending date of your program session, the health information from this exam meets our requirements and can be used for the physical.

We understand the challenge of scheduling your daughter's annual physical. If you will not be able to provide a physical by June 1, 2009, please contact us directly to let us know when you will be able to provide it. The most important information we receive is the information that parents provide about any medical conditions, allergies or other physical and emotional health issues.

Finally, if you are a residential student and will be bringing medication to the program, all medication must be brought in its original labeled containers. All prescription and OTC medication must be kept in the Program Office per DOH regulations. Students will receive their medication on schedule, as prescribed. Epi-pens and inhalers may be kept on the person.

Mailing Address:

Blue Tree Summer Programs
PO Box 380935
Brooklyn, NY 11238

Fax Number:

On the fax cover page, please note that these forms are for the Blue Tree program.

718.237.8862

Phone Number:

800.883.2540

MEDICAL HISTORY AND EXAMINATION FORM

I. MEDICAL HISTORY

MEDICAL HISTORY MUST BE COMPLETED BY THE APPLICANT AND SIGNED BEFORE VISITING THE PHYSICIAN
PLEASE TYPE OR PRINT IN INK

1. NAME

Last

First

Middle

2. DATE OF BIRTH

3. SEX

Male

Female

4. PLACE OF ORIGIN OR PERMANENT RESIDENCE

5. PRESENT ADDRESS

6. N/A

7. DATES

8. Indicate YES or NO. YES answers MUST be explained in the space provided or in the additional space on the following page of this form.

	YES	NO	EXPLANATION
(a) Have you ever had any significant or serious illness(es) or injuries? (State nature of problems / places / dates)			
(b) Have you ever had any operations or been advised by a physician to have an operation? (Describe, include dates)			
(c) Have you had mental illness or depression or have you ever been treated by a psychiatrist? (Describe, include dates)			
(d) Do you currently take medication for treatment of a medical condition (list name / dose), or do you use a medical device?			
(e) Do you have learning differences? Do you take medication for learning needs? (Describe, list name / dose)			
(f) Do you have any allergies? (Please list). Do you take any medication or carry other devices for these allergies?			

9. Do you now have or have you ever had any of the conditions listed below? (Check YES or NO for each item.)

	YES	NO		YES	NO
(a) Epilepsy, convulsions, fits.			(m) Tropical diseases (malaria, bilharzia, amoebiasis, leprosy, filariasis, yaws, etc.)		
(b) Eye diseases, vision defect in one or both eyes.					
(c) Tooth or gum disease.			(n) Depression, anxiety, attempted suicide or other psychological symptoms.		
(d) Asthma, emphysema, or other lung conditions.					
(e) Tuberculosis or exposure to tuberculosis.			(o) Drug or narcotic habit such as marijuana, cocaine, heroin, LSD or any derivatives.		
(f) High / low blood pressure, heart disease.					
(g) Stomach, liver (hepatitis), gallbladder disease.			(p) Bleeding disorder, blood disease, sickle cell anemia.		
(h) Hernia (rupture) / Genito-Urinary / Rectal Disorder.			(q) Tumor, abnormal growth, cyst, or cancer.		
(i) Kidney or bladder condition, stone or blood.			(r) Skin disorder, growths, psoriasis.		
(j) Diabetes, sugar in the urine.			(s) Gynecological disease / abnormal menses.		
(k) Joint disease or injury, swollen or painful joints.			(t) Hearing impairment.		
(l) Back pain, or spinal condition, use of back brace.					

10. If you answered YES to any item in Questions 8 or 9, please explain in detail (include dates of occurrence, treatment, and outcome).
Please use the following page for explanation.

MEDICAL HISTORY AND EXAMINATION FORM

Space for explanation or description of Questions 8 and 9.

11. Name two individuals who could be notified in case of an emergency

Name:

Name:

Address:

Address:

Telephone:

Telephone:

Relationship:

Relationship:

12. I certify that I have reviewed the foregoing information supplied by me, and that it is true and complete to the best of my knowledge. In the event of a serious illness or medical emergency during the summer program, I consent to and hereby authorize staffers of the program to arrange for any medical procedures deemed necessary for my child during the program if neither parent nor guardian is immediately available to otherwise provide consent. I am stating that I am aware of and accept the risk inherent in the program activity. I have read and agree to be subject to the conditions of enrollment as described in the student/parent contract and all other application materials. I attest that all information contained in this form is correct.

SIGNATURE:

DATE:

MEDICAL HISTORY AND EXAMINATION FORM

II. PHYSICAL EXAMINATION

THIS EXAMINATION FORM MUST BE COMPLETED BY A DESIGNATED AND QUALIFIED PHYSICIAN AFTER REVIEWING THE EXAMINEE'S MEDICAL HISTORY AND CONDUCTING A PHYSICAL EXAMINATION. THE PHYSICIAN MUST COMMENT ON ALL POSITIVE AND/OR SIGNIFICANT FINDINGS AND SIGN WHERE INDICATED.

1. APPLICANT'S NAME:

Last

First

Middle

2. HEIGHT:

3. WEIGHT:

4. CORRECTED VISION: 20:

Left

20:

Right

5. BLOOD PRESSURE:

Syst. / Diast.

6. PULSE RATE:

Regular or Irregular (please circle)

7. URINALYSIS:

Sugar

Albumin

Microscopic Examination

8. ELECTROCARDIOGRAM REPORT (only if indicated by history or physical examination):

9. PLEASE LIST ALL MEDICATIONS

Medication

Dosage

Directions

Condition

Physician Phone

10. CLINICAL EVALUATION: (Please provide an answer to each item. Abnormal findings must be fully explained below)

	NORMAL	ABNORMAL	DESCRIBE ABNORMAL FINDINGS
(a) Head, Nose, Mouth			
(b) Ears, Hearing Acuity			
(c) Eyes, Visual Acuity			
(d) Lungs and Chest / Breast			
(e) Heart Rhythm and Sounds			
(f) Vascular System			
(g) Abdomen, Hernia, etc.			
(h) Rectum / Prostate, Hemorrhoids, Fistula			
(i) Urinary System			
(j) Spine and Extremities			
(k) Skin, Lymph Nodes, Scars			
(l) Neurological System / Reflexes			
(m) Emotional Stability			

12. THE PHYSICIAN MUST COMMENT ON ALL ITEMS MARKED YES IN THE MEDICAL HISTORY (PART I) AND COMMENT ON ANY CONDITION DISCOVERED DURING THE EXAMINATION. (PLEASE USE BACK OF PAGE OR ATTACH ADDITIONAL SHEET IF NECESSARY)

13. PHYSICIAN'S SUMMARY STATEMENT AND DIAGNOSIS:

MEDICAL HISTORY AND EXAMINATION FORM

14. IMMUNIZATION HISTORY

MEASLES (Rubeola)

Date of Live Immunization: _____

RUBELLA

Date of Immunization: _____

POLIO

Date series completed, type: _____

MUMPS

Date of Immunization: _____

DIPHTHERIA (DPT), Whooping Cough, Tetanus

Date series completed: _____

TETANUS BOOSTER

Mist Recent: _____

HEMOPHILUS INFLUENZA TYPE B

Date of Immunization: _____

HEPATITIS B

Date of Immunization: _____

VARICELLA (CHICKEN POX)

Date of Immunization: _____

NOTE: HISTORY OF DISEASE
IS NOT ACCEPTABLE PROOF
OF IMMUNITY TO RUBELLA

I have completed my physical examination to the best of my knowledge and have reviewed the applicant's medical history, laboratory evaluations, and immunization record. I certify that the applicant is free of any contagious diseases. It is my opinion that the applicant's physical and emotional condition is satisfactory for a full course of study, research, or lecturing in an academic environment and that there are no limitations on activity or special assistance expected for the duration of the period proposed.

YES NO

SIGNATURE: _____ NAME OF PHYSICIAN (printed) _____

DATE: _____ COUNTRY WHERE LICENSED: _____ NUMBER: _____

ADDRESS OF PHYSICIAN: _____

FOR REVIEWING AUTHORITY USE ONLY:

The applicant's history, physical examination results, and examining physician's opinion have been reviewed and are found to be **complete / incomplete** and **meet the standards / do not meet the standards** for the proposed program.

REVIEWED BY: _____ DATE: _____

SIGNATURE: _____

ORGANIZATION: _____

Blue Tree Summer Program

Telephone: 800.883.2540 Fax: 718.237.8862

To be completed by parent or guardian

Contact, Authorization and Billing Information

Student's Name _____ DOB _____

Allergies _____

Chronic medical problems _____

Medications _____

Name of Physician _____ Phone _____

Medical insurance carrier _____ Policy # _____

Policy holder _____ Group # _____

Parent 1 Name _____

Phone (H) _____ (W) _____ (O) _____

Parent 2 Name _____

Phone (H) _____ (W) _____ (O) _____

PERMISSION FOR MEDICAL TREATMENT

I hereby authorize and grant Girls Dream Out Loud summer program Blue Tree permission to seek treatment and administer care for my daughter, including care and treatment for injuries and illnesses and administration of medication orally or by injection. I also give Girls Dream Out Loud permission to hospitalize and/or secure proper treatment for my daughter in case of medical or surgical emergency, If the physician or hospital involved are unable to communicate with me and if, in their best professional judgment, further delay might jeopardize the welfare of my child I give permission to release pertinent medical information to Blue Tree on a need-to-know basis. I give permission to release information from my child's medical file in order to facilitate proper medical care, and I give permission to all medical providers to discuss my child's medical care with the Director, verbally or in writing.

Signature of Parent or Guardian

Date