TOWN OF BILLERICA
RECREATION DEPARTMENT
248 BOSTON ROAD * BILLERICA, MA 01862
978-671-0921 * FAX 978-671-0927
E-MAIL – billericarecreation@town.billerica.ma.us

HEALTH HISTORY AND EXAM FORM

The information on this form is not part of the acceptance process, but is required for an individual to participate in our program. This information will assist us in identifying appropriate care. This form, except for the “Health Recommendations of Licensed Medical Personnel”, may be completed by the parent/guardian of a minor or by an adult themselves.

Name: ______________________________ Date of Birth: ______________ Male ____ Female ___
Address: ____
Town: ______________________ State: ______________ Zip Code: ______________

Primary Guardian Name: ____
Address: ____
Town: ______________________ State: ______________ Zip Code: ______________
Home Phone Number: ______________ Work: ______________Cell: ______________
E-Mail: ____

Secondary Guardian Name: ____
Address: ____
Town: ______________________ State: ______________ Zip Code: ______________
Home Phone Number: ______________ Work: ______________Cell: ______________
E-Mail: ____

Emergency Contact Name: ______________________________ Relationship: ______________
Phone Number: ______________________ Cell: ______________________

Primary Care Physician’s Name:______________________________ Phone:______________
Address:______________________ City:______________ State:__________
Zip:__________
Name of Family Dentist/Orthodontist:______________________________ Phone: ______________

MEDICAL INSURANCE INFORMATION

Subscriber Name: ______________________ Policy/Group #: ______________________
Carrier Name: ______________________ Carrier Address: ______________________
Does your insurance require notification prior to emergency care or appointment with non primary care physician? ____________
IF YOU HAVE A CARD OR FORM, PLEASE ATTACH A COPY TO THIS FORM.

This health history is correct and complete as far as I know. The person herein described has permission to engage in all activities except as noted. The person herein described understands and agrees to abide by any restrictions placed on participation in program. I agree to inform the Recreation Department of any change in the participant's condition occurring between the completion of this form and the conclusion of the program.

I hereby give permission to the Billerica Recreation Department to provide, seek, and consent to routine health care, supervise the administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission to the Recreation Department to arrange related transportation. I agree to the release of any records necessary for treatment or insurance purposes. It is my intention that the appropriate representatives of the Recreation Department be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Billerica Recreation Department to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips off site.

Signature of Parent/Guardian: ______________________________ Date: ______________

HEALTH CARE Recommendations by Licensed Medical Personnel

I examined this individual on __________. BP ________ Weight ________ Height __________

The individual is under the care of a physician for the following conditions ______________________________
____

Description of any limitation or restriction on camp activities: ______________________________

I have examined the above names individual. In my opinion, the condition of the individual listed above does not preclude his/her participation in an active program.

Licensed Physician’s Signature ______________________________ Date: ______________
Address ______________________________ Phone Number: ______________

Medical History: To be completed by a Physician. A Certificate of Immunization is to be attached. This form must be fully completed before attending program. * = Required for children and staff under 18 years old ** = Required for both staff and children

Immunizations	Dates	Immunizations	Dates	Immunizations	Dates
Polio Vaccine* (TOPV) or (e-IPV)		MMR** (combined) Measles, Mumps, and Rubella		Adult Type Toxoid** (TD) Tetanus/Diphtheria (if more than ten years have elapsed since last dose)	
Tuberculin Screen** Result ________		Hepatitis B* (if born after 1/1/92)		DTP** Diphtheria, Tetanus, and Pertussis	
Haemophilus Influenza B		Varicella Chicken Pox			

Please indicate the medical conditions below that your child has experienced and give approximate dates.

	Date		Date		Date		Date
Chicken Pox		Mumps		Scoliosis		Diabetes	
German Measles		Whooping Cough		Strep Throat		Hypertension	
Measles		Mononucleosis		Congenital Anomaly		Poliomyelitis	
Rubella		Ear Infections		Tonsilitis		Tuberculosis	
Encephalitis		Hepatitis (Type A B C)		Convulsions/Seizures		Kidney Disease	
Meningitis		Bleeding Disorder		Hernia		Heart Disease/Defect	
Scarlet Fever		Rheumatic Fever		Asthma		Eating Disorder	
Visual		Hearing		Emotional/Behavioral			

Has/does the participant have a chronic or recurring illness or condition? ____
____

ALLERGIES List all known Describe reaction and management of the reaction.
Medication, Food, Environmental, Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.
_______________________ ____
_______________________ ____
_______________________ ____

MEDICATIONS BEING TAKEN
Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Identify ALL medications taken daily before or after regular program hours. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. All medication is self administered by the child.

This person takes NO medications on a routine basis.
This person takes medications as follows:

Med #1 __________________ Dosage __________ Specific times taken each day________________________
Reason for taking ____
Med #2 __________________ Dosage __________ Specific times taken each day________________________
Reason for taking ____
Med #3 __________________ Dosage __________ Specific times taken each day________________________
Reason for taking ____
Attach additional pages for more medications.
Identify any medications taken during the school year that participant does/may not take during the summer:
____

DIETARY RESTRICTIONS
Describe ____

ACTIVITY RESTRICTIONS (e.g. what cannot be done, what adaptations or limitations are necessary)
____
____

Use this space to provide additional information about the participant's physical, cognitive, behavioral, or emotional health about which the staff should be aware.

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