

MEDICAL AUTHORIZATION

CAMPER NAME

DATE

I/We agree that in case of an emergency when circumstances make it impracticable (in the sole judgment of Texas Arts Project and St. Stephen's Episcopal School ("School")) to secure our prior approval, School officials are authorized to take whatever actions are deemed necessary in their best judgment to protect the health and welfare of my/our child. This includes, but is not limited to, securing emergency services, anesthetics, medical services (general and specialized) and hospital admission. I/We also grant permission to the School's nursing/training staff to administer health care to my/our child as deemed necessary by them. I/We understand that the cost of such services will be borne by me/us and I/we agree to pay for all medical services provided to my/our child promptly upon receipt of the statement therefore, and I/we further agree to indemnify the School and hold it harmless for any claims, charges or assessments arising out of the School's procuring health care and/or treatment for my/our child. In the event my/our child receives medical treatment, I/we authorize my/our child's physician(s) and any other person or entity in possession of any medical records pertaining to my/our child to release the such medical records to the School. I/We understand that this medical authorization form is in effect and valid for so long as my child is enrolled with Texas Arts Project at St. Stephen's Episcopal School.

PARENT SIGNATURE

DATE

HEALTH INSURANCE INFORMATION

Texas Arts Project does not provide medical insurance for campers. Parents are required to have medical health insurance for their child. Either provide a copy of the insurance card or complete the following:

NAME OF INSURANCE COMPANY

ADDRESS

PHONE

POLICY NUMBER

GROUP NUMBER

EFFECTIVE DATE OF POLICY

NAME OF POLICY HOLDER

INSURED DOB

PHYSICIAN INFORMATION

Texas Arts Project does not provide medical insurance for campers. Parents are required to have medical health insurance for their child. Either provide a copy of the insurance card or complete the following:

PHYSICIAN'S NAME

ADDRESS

PHONE

I hereby certify that the above information is true and correct to the best of my knowledge.

PARENT SIGNATURE

DATE



CAMPER INFORMATION

Date of Camper's Last Diphtheria/Tetanus Booster

Does the camper have any severe allergies to foods (wheezing, breathing problems, generalized hives, shock, upper airway problems)? Please specify specific agents and the type of reaction:

Does the camper have any allergies to medications? If so, please state which medications and the nature of the reaction:

Does the camper have any severe allergies to insect venoms (wheezing, breathing problems, generalized hives, shock, upper airway problems)? Please specify specific agents and the type of reaction:

Does the camper have an adrenaline kit? Yes No

INHALER AND MEDICATION PERMISSION

To be Completed by Parent/Guardian

INHALER PERMISSION

Not Applicable

My child has my permission to carry his/her asthma inhaler(s) and to use as prescribed by their physician. I understand that my child is responsible for the proper use of his/her inhaler medication(s) and that camp staff will not monitor their use.

PARENT SIGNATURE

DATE

MEDICATION PERMISSION

The Texas Arts Project staff will not dispense prescription or non-prescription medications to campers without parental permission. If you want your child to receive a non-prescription or a prescription medication, you must provide the medication in its original container and fill out the following medication questions.

MEDICATION

REASON FOR RECEIVING MEDICATION

DOSAGE TIME TO BE GIVEN

START DATE END DATE

MEDICATION

REASON FOR RECEIVING MEDICATION

DOSAGE TIME TO BE GIVEN

START DATE END DATE

MEDICATION

REASON FOR RECEIVING MEDICATION

DOSAGE TIME TO BE GIVEN

START DATE END DATE

MEDICATION

REASON FOR RECEIVING MEDICATION

DOSAGE TIME TO BE GIVEN

START DATE END DATE

I hereby certify that the above information is true and correct to the best of my knowledge.

PARENT SIGNATURE

DATE



MEDICAL QUESTIONNAIRE

CAMPER NAME _____

This information is confidential and strictly for the use of Texas Arts Project. It will assist us in providing you with optimal medical care while you are a camper at St. Stephen's Episcopal School. It will not be released to anyone without your knowledge and consent.

REPORT OF MEDICAL HISTORY

To be completed by the parent and camper.

1	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any problems with hearing?
2	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Require glasses or contact lenses?
3	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Episodes of syncope or fainting?
4	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine headaches?
5	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tension headaches?
6	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures/convulsions?
7	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent infections of ear?
8	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent infections of throat or tonsils?
9	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent infections of sinuses?
10	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Allergic rhinitis (hay fever)?
11	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma?
12	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Palpitations or irregular heart rhythm?
13	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart murmurs which are not benign?
14	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral valve prolapse?
15	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure?
16	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver disorders, hepatitis?
17	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Peptic or duodenal ulcer?
18	<input type="checkbox"/> Yes	<input type="checkbox"/> No	GE reflex (heartburn)?
19	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent diarrhea or blood in stool?
20	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Irritable bowel syndrome?
21	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcerative colitis or Crohn's disease?
22	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Severe menstrual cramps?
23	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Menstrual irregularity?
24	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Enuresis (bed wetting)?
25	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Previous urinary tract (kidney) infections?
26	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Previous history of kidney stones?
27	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia?
28	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had mononucleosis?
29	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any chronic orthopedic conditions?
30	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fractures?
31	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint dislocations?

32	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint pains, swelling w/o injury?
33	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any severe head injuries/concussions?
34	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Severe illness requiring hospitalization or prolonged incapacitation?
35	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any previous surgery? If yes, please list in comment section
36	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chronic skin problems (eg, acne, eczema, psoriasis, infections, hives)?
37	<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of diabetes, thyroid disease, or other endocrine (hormonal) problems?

38	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any bleeding disorders?
39	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Continuing or previous regular use of alcohol or illicit drugs?
40	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you been diagnosed with ADD?
41	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you take medications for ADD?
42	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Episodes of depression?
43	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Episodes of anxiety or nervousness?
44	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Episodes of obsessive-compulsive behavior?
45	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Previous psychotherapy?
46	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Use of anti-depressants or sedatives?
47	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eating disorder: Bulimia/purging?
48	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anorexia
49	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you smoke or chew tobacco?
50	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had chicken pox? If yes, please list date of illness in the comment section.
51	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you been exposed to tuberculosis?
52	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had a positive tuberculosis skin test in the past?
53	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been on medications for tuberculosis?

Comments or additional information based on above questions.

Do you have any other health or health-related concerns about your child while he/she is away from home?

