



Audubon Society of Rhode Island

HEALTH HISTORY FORM

Parent/Guardian: Please complete both sides of this form and send to **ASRI Education Department, 12 Sanderson Rd., Smithfield, RI 02917, at least three weeks before the program start date.** If your child requires special care or non-oral medication (e.g. injections), you must contact ASRI by phone at (401) 949-5454 x3014 before the program begins.

Camper's Name _____ Birth Date _____ Age _____ Weight _____

Address _____ City _____ State _____ Zip _____

Location (e.g. EEC) _____ Session Name (e.g. Habitats) _____ Camp Dates (e.g. Aug 4-6) _____

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Location (e.g. EEC) _____ Session Name (e.g. Habitats) _____ Camp Dates (e.g. Aug 4-6) _____

Father/Guardian Name _____ Home Phone _____ Work Phone _____

Cell Phone _____ Pager _____

Mother/Guardian Name _____ Home Phone _____ Work Phone _____

Cell Phone _____ Pager _____

Name of other person(s) to contact in case of emergency, if you cannot be reached.

Contact's Name _____ Home Phone _____ Work Phone _____

Cell Phone _____ Pager _____

Contact's Name _____ Home Phone _____ Work Phone _____

Cell Phone _____ Pager _____

Parent/Guardian's Health Insurance Company _____ Policy Number _____

NOTE TO PARENTS: All medications will be locked in a centrally located area, except inhalers and bee sting kits that must be carried by children at all times.

All medications must be properly labeled, correlated with written instructions, and placed in a Ziploc bag. **Notify camp instructor, in person, on first day of camp of any medication to be administered, and hand the medication to the camp instructor. Prescription and over-the-counter medications must be in original bottles with pharmacy labels.**

Prescription Medication: If your child is bringing medication prescribed by a physician, please have your physician attach a note indicating medication order, dosage administration guidelines, and reason for medication. The medication will be dispensed by an authorized staff member.

MEDICAL BACKGROUND FORM

Check either **YES** or **NO**. If yes, please give approximate dates, method of treatment, and/or restrictions. **If your child is under the care of a Social Worker, Psychologist, Behavioral Therapist, etc., please fill in their name, phone number and specific information concerning your child's needs.**

Bleeding Disorders	_____	No	_____	Yes	
Convulsions	_____	No	_____	Yes	
Epilepsy	_____	No	_____	Yes	
Diabetes	_____	No	_____	Yes	
Abscessed Ears	_____	No	_____	Yes	
Asthma	_____	No	_____	Yes	
Allergy Injections	_____	No	_____	Yes	
Sleep Walking	_____	No	_____	Yes	
Fainting	_____	No	_____	Yes	
Kidney Trouble	_____	No	_____	Yes	
Heart Trouble	_____	No	_____	Yes	
Bed Wetting	_____	No	_____	Yes	
* Emotional Problems	_____	No	_____	Yes	
* Behavioral Problems	_____	No	_____	Yes	
* Learning Disability	_____	No	_____	Yes	Please explain: _____
Other	_____	No	_____	Yes	Please explain: _____

List allergic reactions to the following, if applicable. If yes, please note reaction.

Bee Stings:	_____	Don't know	_____	None	_____	Yes	
Medications	_____			None	_____	Yes	
Food or Drink	_____			None	_____	Yes	
Other	_____			None	_____	Yes	

Any special treatment needed? _____ No _____ Yes _____

Received tetanus booster? _____ No _____ Yes _____

All immunizations up-to-date? _____ No _____ Yes _____

Bringing medication to camp? _____ No _____ Yes **If yes, list all prescriptions and over-the-counter products below.**

Medication Prescribed and Over-the-Counter	Dosage	Reason

If you know your child has been exposed to a contagious disease before or during camp, you must notify ASRI immediately.

Permission to secure treatment: I give permission to have my child treated by an Audubon Society of RI authorized staff person or a physician in case of severe illness or emergency in which I cannot be reached. I understand that every effort will be made to contact me before treatment is given. ***Please note that most hospital emergency rooms require notarization for permission to treat a patient. To promote optimal treatment security for your child, please have this form notarized.***

_____ Parent/Guardian Signature (must sign)	_____ Notary (optional)
Date _____	Date _____