Health History Form for Participants at MexArt

Mail this form to the address below:
Carly Cross / MexArt
5802 Bob Bullock Loop C1 #84 -148
Laredo, TX 78041

Name: _____ Birth date: _____

Home Address _____

Social security number of participant _____ Gender: ☐ male ☐ female

Custodial Parent/Guardian _____ Phone: _____

Second Custodial Parent/Guardian _____ Phone: _____

If not available in an emergency, notify:_____

Relationship: _____ Phone: _____

Insurance Information:

Carrier or Plan Name: _____ Group #: _____

Carrier Address: _____

Name of Insured: _____ Relationship to Participant: _____

Social security number of policy holder or insurance ID number: _____

* Important — These boxes must be completed for attendance *

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities as noted.

I hereby give permission to the medical personnel selected by a MexArt Director to order x -rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by MexArt to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips away from San Miguel.

Signature of parent or guardian or adult: _____

Printed Name: _____ Date: _____

I also understand and agree to abide by any restrictions placed on my participation in MexArt activities:

Signature of minor: _____ Date: _____

Health History

The following information must be filled in by the parent/guardian. The intent of this information is to provide MexArt personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to MexArt upon the participant's arrival at the program. Provide complete information so that MexArt can be aware of your needs.

Allergies: List all known (Medications/Foods/Insect stings, etc…)

Describe reaction and management of the reaction

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medications Being Taken

Please list ALL medications (including over-the-counter or nonprescription drugs/vitamins/supplements) taken routinely. Bring enough medication to last the entire session. 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.

Med #1 _____ Dosage _____ Specific time each day _____
Reason for taking_____

Med #2 _____ Dosage _____ Specific time each day _____
Reason for taking_____

Med #3 _____ Dosage _____ Specific time each day _____
Reason for taking_____

Med #4 _____ Dosage _____ Specific time each day _____
Reason for taking_____

Restrictions:

The following restrictions apply to this individual.

- ☐ Does not eat red meat
- ☐ Does not eat poultry
- ☐ Does not eat pork
- ☐ Does not eat seafood
- ☐ Does not eat eggs
- ☐ Does not eat dairy products
- ☐ Other

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

General Questions: Please check the box if the answer is 'YES'.

Has/does the participant:

- ☐ Had any recent injury, illness or infectious disease?
- ☐ Have a chronic or recurring illnes/condition?
- ☐ Ever been hospitalized?
- ☐ Ever had surgery?
- ☐ Have frequent headaches?
- ☐ Ever had a head injury?
- ☐ Ever been knocked unconscious?
- ☐ Wear glasses, contacts, or protective eye wear?
- ☐ Ever had frequent ear infections?
- ☐ Ever passed out during or after exercise?
- ☐ Ever been dizzy during or after exercise?
- ☐ Ever had seizures?
- ☐ Ever had chest pain during or after exercise?
- ☐ Ever had high blood pressure?
- ☐ Ever been diagnosed with a heart murmur?
- ☐ Ever had back problems?
- ☐ Ever had problems with joints?
- ☐ Have an orthodontic appliance being used or brought on trip?
- ☐ Have any skin problems (e.g. itching, rash, acne)?
- ☐ Have diabetes?
- ☐ Have asthma?
- ☐ Had mononucleosis in the past 12 months?
- ☐ Had problems with diarrhea/constipation?
- ☐ If female, have an abnormal menstrual history?
- ☐ Have a history of bed -wetting?
- ☐ Ever had an eating disorder?
- ☐ Ever had emotional difficulties for which professional help was sought?

Please explain any 'yes' answers.

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Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which MexArt should be aware.

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Name of family physician_____Phone_____

Name of family dentist/orthodontist_____Phone_____

Date of Last Physical exam _____

Weight_____ Height_____

The participant is under a doctor's care for the following conditions:

_____

_____

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken Pox
- ☐ German measles
- ☐ Mumps
- ☐ Hepatitis

TB Mantoux Test
Date of last test_____
Result: ___pos. ___neg.

Please give all dates of immunizations for:

DTP	_____	_____	_____	_____	_____
TD (tetanus/diptheria)	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____
MMR	_____	_____			
or Measles	_____	_____			
or Mumps	_____	_____			
or Rubella	_____	_____			
Influenza B	_____	_____	_____	_____	
Hepatitis B	_____	_____	_____		
Varicella (chck.pox)	_____	_____			
BCG	_____				

Notes:

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