NORTHERN CALIFORNIA FLUTE CAMP
Report of Medical History

Please print.
Student's name_____ Date of birth (mm/dd/yy)_____
last first middle initial

Parent's name _____
last first middle initial

Home telephone (_____) _____ Other telephone (e.g., cell, business) (_____) _____
In case of emergency, alternate contact_____
last name first name

Home telephone (_____) _____ Other telephone (e.g., cell, business) (_____) _____

Name of student's physician _____
last first
Physician's telephone (_____) _____

Allergies/Adverse Reactions (Medication, Food or Environmental):
_____
Has the student been prescribed an Epi Pen? (If so, dose and allergen) _____

CHECK if the student has had any problems in the following areas. **Please comment on all checked boxes in the space below.**

- ☐ Childhood Illnesses: (Scarlet Fever, German measles, Mumps, Chicken pox, Rheumatic Fever etc,)
- ☐ Head/Neurological: (headaches, migraines, seizures, head injury etc.)
- ☐ Ears, Nose, Throat, Mouth: (ear infections, hearing loss, sinusitis, strep throat, tonsillitis, dental issues, braces etc.)
- ☐ Eyes: (visual impairment, contact lenses or glasses, infections etc.)
- ☐ Heart: (palpitations, dizziness, fainting, arrhythmia, high/low blood pressure etc.)
- ☐ Lung: (shortness of breath, chest pain, asthma, infections, cough etc.)
- ☐ Musculoskeletal: (broken bones, dislocation, scoliosis, hernia, weakness, paralysis)
- ☐ Gastrointestinal/Metabolic: (abdominal pain, diarrhea, constipation, recent weight gain or loss, Diabetes, hypoglycemia, gallstones, etc.)
- ☐ Genital/Urinary: (Urinary tract infections, kidney stones, gynecological problems etc.)
- ☐ Skin: (rash, eczema, acne, herpes etc.)
- ☐ Psychological: (ADHD, mood disorder, eating disorder, sleep problems etc.)
- ☐ Has the student ever been hospitalized?
  - ☐ Has the student ever had surgery?
  - ☐ Does the student have a chronic illness?
  - ☐ Has the student had physical activity restricted during the past five years?
  - ☐ Has the student consulted or been treated by a psychiatrist or mental health provider?
  - ☐ Has the student ever had a positive skin test for tuberculosis (T.B.)?

Comments: Please provide additional information on all checked boxes (diagnosis, treatment, and dates).

_____
_____
_____
_____
_____
_____
_____

Medication Inventory

Student's name_____ Date of birth (mm/dd/yy)_____
last first middle initial

Medication includes both prescription and non-prescription medications and includes those taken by mouth or by inhaler, those which are injectable, applied as drops to eyes or nose, or applied to the skin.

NON-PRESCRIPTION MEDICATIONS

Students are discouraged from bringing general over-the-counter medications. Health Services provides items such as mild pain relievers, cough suppressants, etc. If students do need to bring special products, please list them below, including all over- the-counter medications, vitamins, skin preparations, herbal items, and food supplements.

NO MEDICATION

☐ Please check here to indicate that you will be bringing no medications (including prescription, non-prescription, and herbal supplements).

PRESCRIPTION MEDICATIONS

PLEASE LIST PRESCRIPTION MEDICATIONS:

Name of Medication	Reason for Use	Directions for Dispensing	Expiration

PARENT ACKNOWLEDGEMENT

By signing below, I acknowledge that I have read the Northern California Flute Camp's medication policies and agree to comply with them. The responses on this Medication Inventory are true and complete to the best of my knowledge. I authorize NCFC to administer prescription medication to the student as listed above.

Parent's signature _____ Date _____

Student's signature _____ Date _____

Medical Insurance Information

Student's name _____ Date of birth (mm/dd/yy)_____
Last First Middle Initial

Front of card Back of Card

Do we have your permission to administer the following over-the-counter medications as needed by your child?

Tylenol	Yes _____	No_____
Advil	Yes _____	No_____
Aspirin	Yes _____	No_____
Aleve	Yes _____	No_____
Ibuprofen	Yes _____	No_____
Pepto-Bismol	Yes _____	No_____
Tums	Yes _____	No_____
Imodium	Yes _____	No_____
Dramamine	Yes _____	No_____
Midol	Yes _____	No_____
Sudafed	Yes _____	No_____
Cough Drops	Yes _____	No_____
Benadryl	Yes _____	No_____
Bug Spray	Yes _____	No_____
Sun screen	Yes _____	No_____

Parent Name (print)_____
First, last

Parent Signature_____

Date_____/_____/20____