**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. NCFC 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**  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Medical Insurance Information**

Student’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth (mm/dd/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last First Middle Initial

**PLEASE ATTACH A COPY OF THE FRONT AND BACK OF THE FAMILY’S MEDICAL INSURANCE CARD**

**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.

I, a parent or legal guardian of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a Northern California Flute Camp student at Hidden Valley Music Seminars, do give my consent for any and all medical aid, treatment, or surgery deemed necessary by a representative of the administration of the staff of Hidden Valley Music Seminars.  I understand that all costs for such aid, treatment or surgery shall be my responsibility and shall be payable upon receipt of billing.  It is also understood that Hidden Valley Music Seminars shall notify the undersigned immediately if any medical aid is deemed necessary.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      \_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian (please print)            Parent or Guardian Signature                          Date

**IMPORTANT: Withholding any information regarding this student’s health or medication is ground for immediate dismissal and/or refusal of future admission.**

Parent’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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\_\_\_\_\_