TRẠI HỌP BẠN THẾ GIỚI HỘI ĐỒNG TRUNG ƯƠNG - HƯỚNG ĐẠO VIỆT NAM

THẮNG TIẾN XII

8-13 July, 2022 Oak Canyon Park 5305 E Santiago Rd, Silverado, CA 92676

www.thangtien12.com www.thangtien12.net

THANG TIEN XII HEALTH HISTORY FORM

Please complete all pages and sign this medical consent form.

Group/Lien Doan Name: _____

Camper Last Name _____ First Name _____ **Camper ID: _____**

Birthdate (MM/DD/YYYY) _____ / _____ / _____ ☐Male ☐Female

Best E-mail _____ Home Phone _____ Cell Hone _____

Camper Address _____ State ____ Zip _____

Name of Parent 1 /Guardian _____

Address (if different from camper) _____ State ____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Name of Parent 2/ Guardian _____

Address (if different from camper) _____ State ____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact Person other than Parent: _____Relationship:_____

Emergency Contact Phone _____

INSURANCE/DOCTOR INFO:

Health Insurance Co. _____

ID/Policy No. Group No. _____

Name of Primary Care Physician Phone _____

List any medications the camper is currently taking:

Medication	Dosage	Instruction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergy

Drug or medication allergy?	☐Yes ☐No	Type of reaction: _____
Peanut or nut allergy?	☐Yes ☐No	Type of reaction: _____
Insect bites/stings	☐Yes ☐No	Type of reaction: _____
Seafood (shellfish, fish, etc.)	☐Yes ☐No	Type of reaction: _____
Pollens/dust?	☐Yes ☐No	Type of reaction: _____
Others:_____	☐Yes ☐No	Type of reaction: _____

Health History **Have you ever been treated for the following?**

High blood pressure	☐Yes ☐No	Asthma	☐Yes ☐No
Stroke/TIA	☐Yes ☐No	Lung/respiratory disease	☐Yes ☐No
Heart attack	☐Yes ☐No	COPD	☐Yes ☐No
Chest pain or angina	☐Yes ☐No	Ear/eye/nose problems	☐Yes ☐No
Irregular heart beat	☐Yes ☐No	Muscle or bone issues	☐Yes ☐No
Head injury/concussion	☐Yes ☐No	Thyroid problems	☐Yes ☐No
Psychiatric or emotional difficulty	☐Yes ☐No	Diabetes	☐Yes ☐No
Behavioral/neurological disorder	☐Yes ☐No	Blood disorder/sickle cell	☐Yes ☐No
Anxiety or panic attacks	☐Yes ☐No	Obstructive sleep apnea	☐Yes ☐No
ADHD/ADD	☐Yes ☐No	Kidney disease	☐Yes ☐No
Sleep disorders/sleepwalking	☐Yes ☐No	Seizure/epilepsy	☐Yes ☐No
Fainting spells/dizziness	☐Yes ☐No	Excessive fatigue	☐Yes ☐No
Home sickness	☐Yes ☐No	Tuberculosis	☐Yes ☐No

Immunization

Tetanus within the past five years?	☐Yes ☐No	Pertussis/Diphtheria	☐Yes ☐No
Measles/mumps/rubella	☐Yes ☐No	Chicken Pox	☐Yes ☐No
Hepatitis A	☐Yes ☐No	Meningitis	☐Yes ☐No
Hepatitis B	☐Yes ☐No	Polio	☐Yes ☐No
Influenza	☐Yes ☐No	Covid-19 (complete)	☐Yes ☐No
		Covid-19 (Booster)	☐Yes ☐No

INFORMED CONSENT AND AUTHORIZATION: I understand that participation in camp activities involves the risk of personal injury, including serious injury and death, due to the physical, mental, and emotional challenges in the activities offered. I understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by applicable rules.

In the event of an emergency involving me or my child, I understand that effort will be made to contact the person listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, I give permission to the medical provider selected by the adult leader in charge to secure proper treatment, including anesthesia, surgery, injection of medication for me or child, and hospitalization. I authorize medical providers to disclose protected health information to the adult in charge, camp medical provider, adult leaders, and/or any physician or health-care provider involved in providing medical care to the participant.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name (Print) _____ Relationship _____

Camper Signature _____Name (print) _____ Date _____

Participant Physical Examination Clearance

Participant Full Name: _____Date of Birth: _____

Name of Physician/Nurse Practitioner/Physician Assistant: _____

Name of Medical Group: _____

Address:_____

City:_____ State:_____ZIP Code:_____

Office Phone Number:_____

EXAMINATION

Height: Weight Blood Pressure:_____/_____ Pulse:_____

	Normal	Abnormal	Explanation
Eyes	□	□	_____
E/N/T	□	□	_____
Lungs	□	□	_____
Heart	□	□	_____
Abdomen	□	□	_____
Hernia	□	□	_____
Genitalia	□	□	_____
Musculoskeletal	□	□	_____
Neurological	□	□	_____
Other	□	□	_____

Examiner's Certification

I certify that I have reviewed the health history and examined this person. I find no contraindications for participation in this camp. The participant:

True	False	
□	□	Meetings height/weight requirements
□	□	Does not have uncontrolled heart disease or hypertension
□	□	Does not have uncontrolled asthma or breathing problems
□	□	Has not had an orthopedic or musculoskeletal injuries within the past 6 months
□	□	Has had no seizures in the past 12 months
□	□	Has no uncontrolled psychiatric disorders
□	□	Does not have poorly controlled diabetes

Examiner's Signature: _____ Date:_____

Examiner's Printed Name: _____