MERCERSBURG ACADEMY SUMMER AND EXTENDED PROGRAMS
HEALTH CENTER – SUMMER MEDICAL FORM 2010

Instructions: Parents should complete Parts 1, 2, and 4. Part 3 should be completed by a physician. All sections must be completed; enter "None" if not applicable. Accurate information will better enable us to provide quality care to your child in case of a problem or emergency.

Return this form to the Office of Summer and Extended Programs by the date noted in your confirmation packet an/or immediately upon completion. This form may be faxed to: 717-328-9072.

Please print in blue or black ink or type.

PART 1 – GENERAL INFORMATION:

Program: ____
Participant's Name: ______________________________
Permanent Address: ____________________________
____
____

Dates of Program: ____/____/____
SS#: ________-________-______________
Date of Birth: ______/______/______
Home Phone: ______________________
Gender: ________ M ________ F

MEDICAL EMERGENCY CONTACT INFORMATION:

Person to contact first:
Name: ____________________________
Relation: ___________________________
Daytime Phone: ____________________
Evening Phone: ____________________
Cell Phone: _________________________

Backup contact (relative or friend):
Name: __________________________
Relation: ________________________
Daytime Phone: _________________
Evening Phone: _________________
Cell Phone: ______________________

INSURANCE POLICY INFORMATION:

The above-named child is covered by health insurance: Yes _____ No _____
If yes, provide the following information which is required by Mercersburg Academy Health Center to expedite treatment and to facilitate the billing process.

PLEASE PROVIDE A PHOTOCOPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD

Policy Holder's (P.H.) Name: ____________________
Address: ____
City/State/Zip: __________________________________
P.H.'s Employer: _________________________________

P.H.'s Date of Birth: ____/____/____
Relation: __________________________
Occupation: ______________________

Insurance Company: ___________________________
Address: ____
City/State/Zip: ___________________________________

Policy #: ___________________
Plan #: _____________________

PART 2 – MEDICAL TREATMENT AND MEDICATION ADMINISTRATION:

I. I, the legal guardian of the above-named participant, authorize the Mercersburg Academy staff to provide medical treatment for the camper as they see necessary at Mercersburg Academy or a nearby facility. I authorize Mercersburg Academy staff members to administer medication as prescribed during the participant's session.

II. I accept responsibility for payment of all services rendered: I authorize any medical facility which renders services to release medical information necessary for treatment or for the processing of claims. I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the Program staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the Program staff will notify me or my designee as soon as possible of any and all diagnoses and treatments.

III. I verify that my child's doctor has determined that he/she can participate in all Summer Programs activities.

_________________________________ _________________________________ ______________________
Parent/Legal Guardian's Signature Print Name Date

Date of Tetanus ____________
Allergies___________________
____

PART 3
Participant's Name: ________________________________

Directions: This form should be completed by a parent or guardian and a physician as applicable. Please answer all questions.
DOES THE PARTICIPANT CURRENTLY HAVE ANY OF THE FOLLOWING? (If yes, please describe)
Does your child use an Epinephrine pen (Epi-Pen)? ______________________________
Drug allergies: ____
Food allergies: ____
Allergies to insect bites: ____
Special dietary needs: ____
Asthma: ____
Frequent headaches: ____
Dizziness or seizures: ____
Diabetes: ____

LIST:
All other health problems: ____

Limitations of Activities:

Medications the participant is currently taking (include dose and frequency):

Will your son/daughter require any specific treatment for a medical/emotional condition? Yes____ No____
Explain:

MEDICAL HISTORY

Date of last tetanus: *(must be within 10 yrs.) _____/______/_____	Date of last medical check –up:
Measles, Mumps, Rubella series completed: yes/no	Hospitalizations in the past 5 years: Describe:
Polio series completed yes/no	
A PPD skin test for tuberculosis is recommended for students who answer YES to ANY of the following questions. • Has a family member or close contact had tuberculosis? • Has a family member had a positive tuberculin skin test? • Are you from a high risk country (a country other than the United States, Canada, Australia, New Zealand, or Western European countries)? • Have you traveled to a high risk country for more than 1 week? • Date of test (If indicated)________ Results: ______________	

To be completed by a physician:
Name of Participant: ______________________________ has been examined by me on this date and found to be free from infectious and contagious disease. All health concerns have been listed above he/she is physically qualified for full participation in activities related to the Summer Programs.

M.D. /D.O. Name: (print)________________________________ M.D./D.O Signature: ______________________________
Address: ________________________ City, State: __________________________

Date: ____ /____ /____ Phone: ______________ Fax: ________________________

PART 4

Mercersburg Academy Summer and Extended Programs
Health Center-Summer Medical Drug Form 2009

Prescription and over-the-counter (OTC) medication
Information/authorization for administration

Please complete the form below. If your participant does not take medicine please indicate below and submit wit h your other forms.

Participant Name: (Last, First) ____

Name of medication(s) and time(s) (see choices) to be administered:

	Medications	Dose	Diagnosis	B	L	D	HS	PRN
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
B=Breakfast; L = Lunch; D = Dinner; HS = Bedtime; PRN = only as needed								

This form is valid for 1 (one) year from date of signature.

PLEASE PROVIDE A PHOTOCOPY OF BOTH THE FRONT AND THE BACK OF YOUR INSURANCE CARD.

If you have questions or concerns, please call the Office of Summer and Extended Programs at 717-328-6225 or the Mercersburg Academy Health Center at 717-328-6136.

Health Center FAX 717-328-6214
Summer and Extended Programs FAX 717-328-9072