



Early College Summer Institute Health Form

The information provided on this form is for the sole use of the UMM Early College Summer Institute staff. It contains private health information that will be kept secure and confidential and used only in the case of emergency.

Participant Name: Last _____ First _____ MI _____

Mailing Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Birth Date _____ **Age** _____ **Gender** _____

Custodial Parent(s) or Guardian(s) (if under 18):

Name: _____ **Phone: Home** _____ **Cell:** _____

Name: _____ **Phone: Home** _____ **Cell:** _____

Home address (if different from above): _____

Emergency Contact: Please indicate 2 different responsible people other than yourself who can be contacted in the event that you cannot be reached.

Name _____ **Name** _____

Relationship _____ **Relationship** _____

Phone _____ **Phone** _____

Family Physician: _____ **Phone** _____

Insurance Information:

Is this person covered by medical and hospital insurance? Yes _____ No _____

If so, provide carrier and plan name _____ ID# _____ Group # _____

A photocopy of both sides of your insurance card must be attached to this form.

Health History

The information provided here by the participant is intended to provide UMM Early College Summer Institute healthcare personnel with the background needed to provide appropriate care, and the program personnel with

the information needed to provide a safe, healthy, and appropriate camp experience. Any changes to this information should be provided to health care personnel upon arrival at camp. *This information will not be used to exclude a participant from participation unless the participant cannot perform program requirements with or without a reasonable accommodation or is determined to be a direct threat to the health or safety of others.*

Allergies

1. Is this person allergic to any food, medication, or other substance? Yes ___ No ___
If yes, please list all allergens and describe your reaction to them:

2. Has this person ever had any unusual reaction to an insect bite or bee sting? Yes ___ No ___
If yes, please explain:

Medications

1. Does this person currently take prescribed medication or treatment (including over the counter and homeopathic remedies)? Yes ___ No ___
2. Does this person self-administer any medication, such as an inhaler, or carry an epipen or anakit? Yes ___ No ___
3. If it is found necessary by the UMM Early College Summer Institute healthcare personnel, do you consent to this person being given common, over-the-counter medications such as Benadryl, Caladryl, Tylenol, Advil, Motrin, Pepto Bismol, Maalox, Imodium, Tums, Sudafed, cough medicine. Yes ___ No ___

Please list ALL medications (including over the counter medications and homeopathic remedies) **taken routinely.** Bring enough medication to last the entire camp session. ALL items should be in their original packaging, bottle, or container that identifies the prescribing physician (if a prescription drug). The name of the medication, the dosage, and the frequency of administration. **Attach additional pages if necessary.**

Medication #1 _____ **Dosage** _____ **Specific time taken each day** _____

Reason for taking _____

Medication #2 _____ **Dosage** _____ **Specific time taken each day** _____

The University of Maine at Machias is an EEO/AA employer and does not discriminate on the grounds of race, color, religion, sex, sexual orientation, transgender status, gender expression, national origin, citizenship status, age, disability, genetic information or veteran's status in employment, education, and all other programs and activities. The following person has been designated to handle inquiries regarding non-discrimination policies: Director of Equal Opportunity, 101 North Stevens Hall, University of Maine, Orono, ME 04469-5754, 207.581.1226, TTY 711 (Maine Relay System), coinfo@umit.maine.edu

Reason for taking _____

Medication #3 _____ Dosage _____ Specific time taken each day _____

Reason for taking _____

Dietary Restrictions – Please check all that apply

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

Other (please describe): _____

Immunization Record – Please provide the date each immunization was received (or provide a copy of this person’s immunization record from your health care provider)

- | | |
|---|---|
| _____ Hepatitis B (Hep B) | _____ Influenza (IIV, LAIV) |
| _____ Rotavirus (RV, RV1, RV5) | _____ Measles, mumps, rubella (MMR) |
| _____ Diphtheria, tetanus, pertussis (DTaP, Tdap) | _____ Varicella (VAR) |
| _____ Haemophilus influenza type b (Hib) | _____ Hepatitis A (HepA) |
| _____ Pneumococcal conjugate (PCV13) | _____ Human papillomavirus (HPV2, HPV4) |
| _____ Pneumococcal polysaccharide (PPSV23) | _____ Meningococcal (Hib-MenCY) |
| _____ Inactivated poliovirus (IPV) | _____ MenACWY-D, MenACWY-CRM) |

Disabilities or Physical Restrictions (Optional)

Please describe any disabilities or physical restrictions for this person of which you want us to be aware, and any reasonable adaptations or accommodations that are requested (attach a separate piece of paper if needed).

Any person with a disability who needs accommodations for the program should contact the appropriate Camp Director to discuss their needs, preferably at least 21 days in advance. Shorter notification may mean we will not be able to provide accommodation at the start of the program.

Christy Alley, Director of Early College, christy.alley@maine.edu or 207-207-1268

Please use this space to provide any additional information about this person’s behavior and physical, emotional, or mental health (such as sleepwalking) that UMM Early College Summer Institute staff members should be aware of to provide a safe, healthy, and appropriate camp experience. (Optional)

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The UMM Early College Summer Institute will send anyone home in accordance with the University of Maine policy, ACA medical and DHHS policy if they have signs of serious contagious illness.

Parent or Guardian Authorization: This health history is correct and complete as far as I know. The person herein described has permission to engage in all program activities except as noted in this Health History. I hereby give permission to UMM Early College Summer Institute to provide routine health care, administer prescribed or other medications, and seek emergency medical treatment including ordering x-rays or routine tests. I give permission to UMM Early College Summer Institute staff to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission for the physician selected by UMM Early College Summer Institute staff to secure and administer treatment, including hospitalization, for my child. This completed form may be photocopied for trips. I also understand and agree that my child will abide by an restriction placed on their participations in a program activities by medical personnel.

Parent, GuardianSignature: _____

Printed Name: _____

Date: _____