MATHPATH 2019 HEALTH, DIET AND BEHAVIOR FORM

This form has 4 pages. The parent or guardian must sign several places on page 3. The student's doctor must sign on page 4. The information and signatures are necessary in the event your child needs medical treatment at MathPath. You or your physician should attach extra sheets if more space is needed. Submission of this completed form by a parent or guardian, by *May 31, 2019*, is required before a student can attend. *Please do **not** staple these pages together. Please do **not** print them 2-sided.*

PAGE 1: CONTACT AND INSURANCE INFORMATION

STUDENT INFORMATION

Student's Name_____ Gender _____

Permanent Address _____ Date of Birth _____

City/State/Zip _____ Home Phone _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to contact first:

Name_____

Relation to student _____

Daytime Phone _____

Evening Phone _____

Email_____

Backup contact (relative or friend):

Name _____

Relation to student_____

Daytime Phone _____

Evening Phone_____

Email _____

INSURANCE POLICY INFORMATION for a policy valid in at least the Michigan counties of Kent and Ottawa (Grand Rapids metropolitan area). It must cover at least *urgent* and *emergency* care, at least until August 1, 2019, and extending beyond that if your child must be hospitalized beyond the end of MathPath. In most cases your proof of insurance is a plastic card, usually in the child's name. If so, with this form please send clear scans – not photos – of both sides of the insurance card your child presents when seeking coverage. All numbers on the scan must be readable. Our experience is that photos, especially cell phone photos, are almost never clear enough to read all the numbers. If you are using temporary (travel) insurance, please send a scan of your certificate. If you can't do either, then not only must you fill the lines below, but also your child *must* bring their card/certificate to camp, and carry it on their person at all times.

Rest of this page to be filled out only if you cannot provide scans of your insurance info; we strongly prefer the scans. Insert scans between pages 1 and 2 of this form.

Policy Holder's (P.H.) Name _____ P.H. Date of Birth _____

P.H. Address_____ Relation to Student _____

P.H.'s Employer _____

Insurance Company Name _____

Insurance Company Address _____

Policy # _____ Plan #_____

Insurance Co. phone number for Customer Service _____ If the Insurer has different numbers for out-of-area coverage or precertification, please give those here:

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PAGE 2: MEDICAL AND BEHAVIOR CONDITIONS AND FOOD RESTRICTIONS

Student's Name: _____

DOES THE STUDENT CURRENTLY HAVE ANY OF THE FOLLOWING?

For each item, if your child does not have it, write No so we know you looked at it. If Yes, please describe, including how severe; if life threatening we must know. If you need more space there are extra lines at the bottom.

Drug allergies:_____

Food allergies:_____

_____

Seasonal allergies: _____

Environmental allergies: _____

Allergies to insect bites: _____

Special dietary needs, whether medical, religious or by choice: _____

_____

Asthma:_____

Frequent headaches: _____

Dizziness or seizures: _____

Other medical conditions, including ADD and ADHD:_____

_____

Limitations on Activities: _____

_____

Behavioral Problems: (Please describe any you know of or think might be a problem while s/he is away from home; we can help your child best if we know in advance what might happen) _____

_____

Extra lines for anything else you want to tell us or overflow from above: _____

_____

_____

_____

_____

_____

_____

_____

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PAGE 3: TREATMENT CONSENTS

All 3 consents below must be completed and signed even if not currently relevant

Student's Name: _____

Medications the student is currently taking, dosages and frequencies and whether they are over the counter or prescription.

_____

_____

_____

_____

MEDICATIONS CONSENT. The default is that students will deposit their medications with our nurse, and will come each day to the nurse's station to be given those medications. If you child is taking medications, you may choose to have him/her self-medicate with your signed consent below.

Nurse will administer ☐ Student will self-administer ☐ (Must chose one even if no medications currently)

Parent or guardian signature _____ Date _____

COMMON REMEDIES CONSENT. By your signature below, you give permission for the nurse to administer the following. *Please cross out any you do not wish to allow, then sign*.

Ibuprofen, Tylenol, Aspirin, Benadryl, cough drops, zyrtec, midol for cramps, pepto bismol for stomach upset, Dramamine for motion sickness, hydrocortisone.

Parent or guardian signature _____ Date _____

MEDICAL TREATMENT CONSENT (signature required)

I, the legal guardian of the above-named student, authorize MathPath staff to seek medical diagnosis and treatment for the student as they see necessary. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide MathPath staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the above-named student. I authorize any medical facility that renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, MathPath staff will make a good faith effort to contact me or the emergency contacts on page 1 before seeking treatment. If this is not possible, I understand that MathPath staff will notify me or my designee as soon a possible of any and all diagnoses and treatments.

_____	_____	_____
Legal Guardian's Signature	Print Name	Date

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PAGE 4: MEDICAL HISTORY AND PHYSICIAN'S AUTHORIZATION

Student's Name: _____

MEDICAL HISTORY or attach your own form

IMMUNIZATION DATES:

Measles_____

Mumps _____

Rubella _____

OR MMR_____

Last Tetanus _____

(DPT, TT or TD) _____

Polio Series _____

Other _____

Date of last medical check-up (should be after June 30, 201*8*): _____

Reasons for any hospitalizations in the past 5 years:

_____

_____

_____

_____

_____

PHYSICIAN'S SECTION please print

Note: Physicians must sign this form, even if they provide and sign their own form for the medical history, because the physician must attest to statements 1) and 2) below.

Dear Physician: The typical choice of MathPath physical activities are, on campus: basketball, frisbee, pickleball, racquetball/squash, soccer, tennis, swimming; off-campus if available, canoeing, cycling, hiking, ice-skating, kayaking, indoor or outdoor rock climbing, tubing and whitewater rafting.

Physician's Name: _____

Address: _____

City/State/Zip _____ Telephone _____

1) I have examined the above named student and found that s/he is able to participate in all activities of MathPath. (If exceptions, cross out entries above or add a statement below.)

2) I have reviewed the prescription medications listed on page 3 and authorize this student to take those medications at MathPath.

_____ _____

Physician's Signature Date