2013 Washington College Geospatial Discoveries Summer Program
Medical Information Form

Participant's Name: _____ Date of Birth: _____
Home Address: _____ Home Phone: _____
_____ E-mail: _____

EMERGENCY CONTACT:

1. Name: _____ Relationship: _____
Home Phone: _____ Office Phone: _____ Cell Phone: _____
2. Name: _____ Relationship: _____
Home Phone: _____ Office Phone: _____ Cell Phone: _____

HEALTH INFORMATION:

Please describe any condition requiring medication as treatment: _____
_____

List any medications which have been prescribed by the family doctor for the participant to take on her/his own while attending the program:
_____
_____

List any allergies (food, medicine, general): _____
Any surgery in the past year? **Yes** **No** If yes, please explain: _____
Name of Family Physician: _____ Phone: _____

INDICATE HEALTH HISTORY: (please explain any checks)

- ☐ Respiratory problems-Asthma, Tuberculosis, persistent cough, etc.
- ☐ Heart Problems-High or low blood pressure, Rheumatic Fever, etc.
- ☐ Stomach or intestinal problems-ulcers, jaundice, hernia, colitis, indigestion, etc.
- ☐ Eye, Ear, Nose, Throat-Hay fever, ear infections, impaired sight or hearing
- ☐ Nervous disorder-convulsions, epilepsy, dizziness, etc.
- ☐ Skin disease
- ☐ Emotional or mental disorders
- ☐ Recent exposure to a contagious disease
- ☐ Currently under a doctor's care
- ☐ Physical limitations
- ☐ Kidney, gall bladder, or liver disease
- ☐ Diabetes or hypoglycemia
- ☐ Muscular/Skeletal-arthritis, recent fractures

Approximate date of last physical: _____
Please explain any checks: _____
_____

IMMUNIZATION INFORMATION:

Per the Health Department's requirements, all campers must provide a photocopy of their immunization records. We will be unable to accept your child on registration day without this information.

Camper Name: _____

RECOMMENDATIONS AND RESTRICTIONS:

Any treatment to be continued: _____

_____

Any medications to be administered (special dosages). All medicines must be in original containers:

_____

_____

Any medically prescribed meal plan or dietary restrictions: _____

_____

Are there any special accommodations that are needed in order to participate in the program?

_____

_____

Please list anything the staff needs to know about your camper: _____

_____

_____

PARENTAL AUTHORIZATION FOR EMERGENCY MEDICAL CARE: (must be signed by parent/guardian)

If medical information changes I agree to notify the GIS Summer Program Coordinator. I hereby authorize you, in the event of an emergency, that is, when you are unable to reach me for authorization or when circumstances require immediate action, to proceed according to good medical practice with treatment of my daughter/son. Also, I authorize the hospital attending physician, or other health care specialist administering the treatment to release pertinent information to the insurance company assuming coverage for the same.

Parent/Guardian's Signature: _____ Date: _____

- ☐ **You must provide a photocopy (front and back) of your insurance card!**

Washington College encourages persons with disabilities to participate in its programs and activities. If you anticipate needing any type of accommodation or have questions about the physical access provided, please contact Carol Wagner (443-282-0010) in advance of your participation or visit.

Washington College is committed to the policy that all persons shall have equal access to programs, facilities, admission, and employment without regard to personal characteristics not related to ability, performance, or qualifications as determined by the College policy or by state or federal authorities. It is the policy of the College to maintain an academic and work environment free of discrimination, including harassment. Washington College prohibits discrimination and harassment against any person because of age, ancestry, color, disability or handicap, national origin, race, religious creed, sex, sexual orientation, or veteran status. Discrimination or harassment will not be tolerated at Washington College.