HS2HC SUMMER CAMP FORMS

ALLERGY NOTICE 1

High School To Health Care (HS2HC) is committed to a nut or nut related products free zone. We ask that parents do not send these products with their students to any of the locations where activities are held. Lunches are provided by the local district in accordance with school district policies. Lunches will contain dairy products. We will attempt to provide copies of lunch menus in a timely manner. However, please notify the staff if any item is an issue for your student. Please fill out the health registration as fully as possible.

STUDENT HEALTH REGISTRATION FORM

Parent Name-First	**Parent Name-Last**
Student Name-First	**Student Name-Last**

This questionnaire is designed to aid program staff in anticipating any health concerns that might affect your child's safety or learning.

MEDICAL

Does your child have a doctor or nurse practitioner? Yes ___ No____

Name of child's doctor or nurse practitioner _____ phone number _____

DENTAL

Does your child have a dentist? Yes ____No ____Name of child's dentist _____ phone number _____

Did your child receive a dental exam in the last 12 months? Yes____ No___ Don't know _____

Describe the condition of your child's teeth? Good _____ Fair ____Poor ____ Don't know ____

INSURANCE

Does your child have medical insurance coverage? Yes ____ No ____ Don't know ____	Name of provider_____
Does your child have dental insurance coverage? Yes ____ No ____ Don't know ____	Name of provider_____

Does Medicaid insure him/her? (Apple Health for kids) Yes ____ No ____ Don't know ____

MEDICAL HISTORY

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? Yes ***** _____ No ____ Describe: _____

Does your student have medication for the condition, and do they know how to use it?

Does your child take any medication? Yes _____ No _____ If yes, name of medication: _____

Explain any concerns the project teams need to know about:

***If your child needs to take medication at school, please Note that staff will not administer medicine to any student.**

Purpose _____Will medication be needed at school? Yes*____ No _____

HEARING/VISION

Does your child wear hearing aids? Yes ___ No ___

Does your child wear glasses or contacts? Yes ___ No ___

SPEECH/LANGUAGE

Does your child wear hearing aids? Yes ___ No ___

Do others have difficulty understanding your child? Yes _____ No ____If yes, please explain:

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent/Guardian Signature_____ Date

Allergy Assessment Form

Student Name: _____ Date of Birth: _____ Date:_____

Parent/Guardian: _____Phone:_____Cell/work:_____

Health Care Provider (name) treating food allergy: _____Phone:_____

Do you plan for your child to receive Summer lunch meals? Yes _____
Does your student have an allergy Yes_____. No_____
*If you answered "Yes" to any question in the "Allergies Section, Please Complete Food Allergy Assessment form below

ALLERGIES

Plants ☐ Animals ☐ Food ☐ Dairy ☐ Mold ☐ Drugs ☐

Bees ☐ Other ☐

Check the foods that have caused an allergic reaction:

- ❑ Peanuts
- ❑ Peanut or nut butter
- ❑ Peanut or nut oils
- ❑ Fish/shellfish
- ❑ Soy products
- ❑ Tree nuts (walnuts, almonds, pecans, etc.)
- ❑ Eggs
- ❑ Milk

Please list any others: _____

How many times has your student had a reaction? ❑ Never ❑ Once ❑ More than once, explain:_____

Please describe the allergic reaction and the treatment for **each** checked allergy or known allergy:

When was the last reaction? _____

Are the food allergy reactions: ❑ staying the same ❑ getting worse ❑ getting better

Do **you think** your child's allergy may be **life-threatening**? ❑ No ❑ Yes

Did your student's **health care provider tell you** the food allergy may be **life-threatening**? ❑ No ❑ Yes

Treatment

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

❑ No ❑ Yes, explain: _____

❑

Does your student understand how to avoid foods that cause allergic reactions? ❑ Yes ❑ No

What treatment or medication has your health care provider recommended for use in an allergic reaction?