Health History and Examination Form

Desired Move-In Date:	
Email this form to: Kenadie@hershe.vegas or fax this form to HerShe Las Vegas, Inc. (888) 272-9488	

The information on this form is not part of acceptance process, but is gathered to assist us in identifying appropriate care. Health history must be filled out by parents/guardians of minors or by adults themselves. Update required annually. Health exam must be completed by approved licensed medical personnel at least every two years. This form has been developed and approved by the American Academy of Pediatrics.

GENERAL INFORMATION

Participant's Name *Last First Middle*	**Birth date**	**Age:**
Current type of placement:		
Social security number of participant	***(circle one)*** **Male Female**	
Custodial parent/guardian	**Cell Phone** **Home Phone**	
Current or last address *Street address City State Zip*		
Other address *Street address City State Zip*	**Phone**	
IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY:		
Name	**Relationship**	
Address	**Cell Phone** **Home Phone**	

INSURANCE INFORMATION

Is the participant covered by medical/hospital insurance? Yes No
If so, indicate carrier or plan name:
Photocopy of front and back of health insurance card must be attached to this form

Important - These boxes must be complete for acceptance*

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.

I hereby give permission to HerShe to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to HerShe to arrange necessary related transportation.

Signature of parent/guardian/social worker or participant if 18 or over
_____

Print Name _____
Date_____

I also understand and agree to abide by any restriction placed on my participation in activities that could be adverse to my health.

Signature of Participant _____ Date
_____

HEALTH HISTORY

The intent of this information is to provide health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to health personnel upon participant's move-in date. Provide complete information so that HerShe can be aware of your needs.

ALLERGIES: List all known

Medication allergies (list)	**Describe reaction and management of the reaction**
Food allergies (list)	
Other allergies (list) Include insect stings, hay fever, asthma, animal dander, ect.	

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person takes NO medications on a routine basis.

☐ This person takes medications as follow:

Med #1 _____Dosage_____ Specific times taken each day _____

Reason for taking

_____

Med #2 _____Dosage_____ Specific times taken each day _____

Reason for taking

_____

Med #3 _____Dosage_____ Specific times taken each day _____

Reason for taking

_____

Attach additional pages for more medications.

RESTRICTIONS
The following restrictions apply to this individual:

Dietary

☐ 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 (describe)

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

GENERAL QUESTIONS (Explain "yes" answers below.) Has/does the participant

Yes	No		Yes	No	
		1. Had any recent injury, illness or infections diseases?			13. Ever been diagnosed with a heart murmur?
		2. Have a chronic or recurring illness/condition?			16. Ever had back problems?
		3. Ever been hospitalized?			17. Ever had problems with joints (e.g. knees, ankles)?
		4. Ever had surgery?			18. Have an orthodontic appliance being brought to camp?
		5. Have frequent headaches?			19. Have any skin problems (e.g., itching, rash acne)?
		6. Ever had a head injury?			20. Have diabetes?
		7. Ever been knocked unconscious?			21. Have asthma?
		8. Wear glasses, contacts or protective eye wear?			22. Had mononucleosis in the past 12 months?
		9. Receiving BST or PSR services?			23. Had problems with diarrhea/constipation?
		10. Ever passed out during or after exercise?			24. Have problems with sleepwalking?
		11. Ever been dizzy during exercise?			25. If female, have an abnormal menstrual history?
		12. Ever had seizures?			26. Have a history of bed-wetting?
		13.Ever had chest pain during or after exercise?			27. Ever had an eating disorder?
		14. Ever had high blood pressure?			28. Ever had emotional difficulties for which professional help was sought?

Please explain any "yes" answers, noting the number of the questions.

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which HerShe should be aware.

Name of physician_____ Phone_____

Address

_____

Name of dentist/orthodontist _____ Phone _____

Address

_____

The applicant is under the care of a physician for the following conditions:

_____

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (HerShe requires that exams cannot me more than 12 months old.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant ☐ is ☐ is not able to live independently.

Signature Of Licensed Medical Personnel: _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

Screening Record (For HerShe Personnel Only)

Date screened _____

Time _____

Meds received

_____

Observation notes

_____