**“e” inc.’s Winter Science Discovery Program**

**2025 Health History and Medication Form**

**Instructions:** A parent/guardian must complete this form for the attending child. Please keep a copy of the completed form for your records. **A copy of your child’s immunization record is required before we can consider your registration complete.**

**Child information:**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_Male \_\_\_\_Female \_\_\_\_\_\_\_\_\_\_\_\_Other

DOB: \_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Care Information:**

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Camper: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Alerts:**

|  |  |  |  |
| --- | --- | --- | --- |
| **General Health Questions** | **Yes** | **No** | **If YES, provide details:** |
| Allergies to Medicine |  |  | EpiPen?  (circle) |
| Food Allergies & Dietary Restrictions |  |  | EpiPen?  (circle) |
| Peanut/Nut Allergy |  |  | EpiPen?  (circle) |
| Environment/Seasonal Allergies |  |  | EpiPen?  (circle) |
| Bee Sting/Insect Bite Allergies |  |  | EpiPen?  (circle) |
| Hospitalization or Surgery |  |  |  |
| Asthma |  |  | Inhaler? |
| Diabetes |  |  | Injection? |
| Seizure Disorder |  |  |  |
| Heart Problems |  |  |  |
| Bladder Problems |  |  |  |
| Fears |  |  | Suggested supports: |
| Frequent Headache |  |  |  |
| Other: | | | |

**\* It is required that all program attendees are able to administer their own injections (EpiPen, inhaler, etc.)**

**Medication Taken During the Program**

* Must be in the original labeled pharmacy container.
* Parents must sign a consent form prior to medications being administered by **“e” inc.** staff.

This child will bring the following medications to the program:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Medication | Amount/Dose | How it is given (ex. by mouth) | When it is given | Reason for Taking |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Permission to Dispense Over-the-Counter Medications** (check permitted)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Sunscreen |  | Insect Repellent |  | Acetominophen (Tylenol) |  | Ibuprofen (Advil) |  |
| Diphenhydramine (Benadryl) |  | Antibiotic Cream (Neosporin) |  | None of these |  |  |  |

I understand that **“e” inc.** is rendering a service and does not assume any responsibility in this matter. I hereby authorize **“e” inc.** to administer/dispense, to my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the prescription and over-the-counter medication(s) checked above.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION**: The above health history is correct and complete to the best of my knowledge. I give permission to **“e” inc.** to provide health care and/or treatment and to share my child’s emergency information and health history form information with appropriate program staff, when necessary, and for treatment, referral, billing or insurance purposes.

Every effort is made to contact parents/guardians in case of medical emergency; however, in the event that a parent/guardian cannot be reached. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give permission to **“e” inc.** and the physician selected by the organization executive director to give, administer and render any treatment or aid, including anesthetics or surgery, as is necessary to protect, preserve, and safeguard the life and health of our camper, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please submit a copy of your child’s immunization record with this form.**