ACADIA INSTITUTE OF OCEANOGRAPHY
Health History and Examination Form

Name_____ Birthdate_____ Sex _____ Age_____
Last First Middle Initial

Parent or Guardian _____

Student's Address_____ Phone _____
Street or P.O. Box *Home*

_____ Phone _____
City State Zip Code *Business*

Second Parent or Guardian or Emergency Contact

Address_____ Phone _____
Home

_____ Phone _____
Business

Additional emergency contact_____ Phone _____
Home

Relationship to student_____ Phone_____
Business

Operations or serious injuries (*dates*)_____

_____

Circle any medical issues which the student is currently treated for by a doctor (circle all that apply):
Asthma for which student requires inhaler **Severe allergy for which student requires epi pen**
If either is circled, please submit an Action Plan with the health form

Explain source of allergy or need for inhaler:_____
Dietary restrictions _____
Current medications (*see back of form*)_____

_____

Other medical concerns_____

_____

Name of dentist/orthodontist_____ Phone_____
Name of family physician_____ Phone_____
Medical/hospital insurance information (*please attach copy of card, if available*)*
Carrier_____ Policy/Group #_____ *though the emergency room of MDI Hospital will accept the health insurance info on out of state patients, the local of state patients, the local health clinics require payment at time of service with cash or credit card. In this case, the credit card. In this case, the clinic or our nurse may call for credit card information.

Any mental health issues _____

_____

Additional health-related suggestions for this person?_____

_____

For Females:
Has this person menstruated? _____ If not, has she been told about it?_____
If so, is her menstrual history normal?_____Special considerations_____

The following must be completed for attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all AIO activities except as noted. **Authorization for treatment:** I hereby give permission to the medical personnel selected by the AIO Director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes. In the event I cannot be reached in the case of an emergency, I hereby give permission to the physician selected by the AIO Director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips off site.

Signature of parent/guardian or adult student _____
I also understand and agree to abide with the restrictions placed on my activities at AIO:

Signature of minor or adult student/staff_____ Date_____

Vaccines	Date of Basic Immunization	Date of Last Booster
Diptheria Pertussis (Whooping Cough) } DPT Tetanus or	1 2 3	1 2
Tetanus Diphtheria } Tdap or		
Tetanus Td		
IPV Polio vaccine		
Hepatitis A vaccine		
Measles (hard or red measles, Rubelola)		
Hepatitis B Vaccine		
Human papillomavirus vaccine HPV		
Varicella vaccine VAR		
Meningococcal Serogroup		
Haemophilus influenza b (HIB)		
Pneumococcal PCV13 or PPSV23		
Covid-19 vaccine: type:		

Health Care Recommendations (to be completed by a licensed health care provider)

I have examined the above applicant within the past year. Date Examined_____

Height_____Weight_____ Blood Pressure_____

This applicant is under the care of a physician for the following:

Treatment (include current medications)

Explanation of any reported loss of consciousness, convulsion, or concussion

Does applicant have epilepsy? _____ Yes _____No Does applicant have diabetes? ____ Yes _____ No

Are there any mental issues AIO should be aware of?

Recommendations and Restrictions while at AIO:

Any treatment/medication to be continued(list specific dosages)

Any medically prescribed meal plan or dietary restrictions

Any allergies (*food, drugs, plants, insects, etc*)

Does the student have any history of knee or back problems?

Activities to be encouraged or limited? Additional Health Information?

Health Care Provider's Signature (DO,PA,MD,NP)_____

Address_____ Phone _____ Date _____