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

Health History
(give approximate dates)
_____ frequent ear infections
_____ heart defect/disease
_____ convulsions
_____ diabetes
_____ bleeding/clotting disorder
_____ hypertension
_____ mononucleosis

Diseases
_____ chicken pox
_____ measles
_____ German measles
_____ mumps
_____ rubella
_____ meningitis

Allergies (check applicable)
_____ hay fever
_____ ivy poisoning, etc.
_____ insect stings
_____ penicillin
_____ other drugs
_____ asthma
_____ other (specify)_____
_____

Operations or serious injuries (*dates*)_____
_____
Chronic or recurring illness or medical condition_____
_____
Dietary restrictions_____
Current medications (*see back of form*)_____
Other diseases or 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 will 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?_____
it?_____
If so, is her menstrual history normal?_____ Special considerations_____
considerations_____

_____

<u>The following must be completed for attendance</u>

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 or guardian or adult student/staff_____
<u>I also understand and agree to abide with the restrictions placed on my activities at AIO:</u>
Signature of minor or adult student/staff_____ Date_____

Vaccines	Year of Basic Immunization	Year of Last Booster
Diptheria Pertussis (Whooping Cough) } DPT Tetanus	1 2 3	1 2
Tetanus Diphtheria } TD or		
Tetanus Td		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard or red measles, Rubelola)		
Mumps		
Rubella (German measles, 3-day measles)		
Varivax (chicken pox)		
Tuberculin test given (most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		
Other vaccinations		

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 students 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 of Form Completion_____ By _____

Rev. 06/10