MEDICAL FORM

Must be submitted at least 3 weeks prior to attendence.

Melwood Recreation Center
9035 Ironsides Road, Nanjemoy, Maryland 20662
Phone 301-870-3226 • Fax 301-870-2620

*This form must be filled out ANNUALLY. Attach a medical exam dated within **2** years of the program date, or have a physician complete and sign the medical exam box on the next page.*

Name ______________________ **Social Security No.** ______________

Health History *Please check and explain any past health issues*

- ☐ Heart defect/disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Ear Infections
- ☐ Asthma
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Hay Fever
- ☐ Measles
- ☐ Swimmer's Ear
- ☐ Poison Ivy
- ☐ Mononucleosis
- ☐ Other: ______________

Explain: ____

____

Does this person have an active seizure condition? ☐ Yes ☐ No Type: ______________

Frequency: ____________ Length of seizure: ______________ Triggers: ____________

Does this person have any hearing issues? ☐ Yes ☐ No
If yes, describe: ____

Does this person have any vision issues? ☐ Yes ☐ No
If yes, describe: ____

Does this person have any allergies? ☐ Yes ☐ No
If yes, describe: ____

Should treatment for allergies be performed by a physician? ☐ Yes ☐ No
Can treatment for allergies be administered in absence of a physician? ☐ Yes ☐ No

Is this person exempt from any immunization requirements? ☐ Yes ☐ No if yes, include documentation

Is this person enrolled in Maryland state schools? ☐ Yes ☐ No if no, please see below

If this person is over the age of 18 or is not enrolled in a Maryland school, you **must** fill out below or attach a copy of Certification of Immunizations. **Please fill out or attach immunization record below.**

Immunization	**Date**	**Date**	**Date**	**Date**	**Date**
DTP (Diphtheria,Tetanus and Pertussis)					
OPV (Oral Poliovirus Vaccine)					
MMR (Measles, Mumps, Rubella)					
HbPV (Haemophilus b Conjugate Vaccine)					
Tuberculin					
** TET-TOX (Tetanus Toxiod)					
Other:					
Other:					
*****Date of last Tetanus shot is required for all participants***					

Health Insurance: ______________________ Policy Number: ______________

Primary Care Physician: ______________________ Phone Number: ______________

Please list any medical or psychological information about the person that is important to their care and well being:

Medical Release & Authorization *Must be signed by the legal guardian*

I have reviewed this completed Medical Form. All information provided is correct to the best of my knowledge and the individual described above has permission to engage in all activities except as noted.

In case of emergency, I understand that every effort will be made to contact the legal guardian or the emergency contacts listed on the individual's registration form. In the event that legal guardian or emergency contact can not be reached, permission is given to Melwood to secure proper treatment including hospitalization, necessary tests, surgery, anesthesia or injections of medication for me/the individual. Permission is given to transport me/the individual for medical assistance. It is understood that the individual or the legal guardian is responsible for payment of all medical treatment. This form may be photocopied for use.

State regulations require permission to allow Melwood to administer medications to the individual while at camp or recreation program. It is required that the first dose of all medication be administered at home. I hereby give my permission for Certified Medication Administration staff to give medication to the individual while they are at camp or recreation program.

Legal Guardian Name (Please Print): ____

Legal Guardian Signature: ____________________________________ Date: ______________

Medical Exam Information *To be completed by a health care provider and dated within 2 years*

Blood Pressure: ___________ Weight: ___________ Height: ___________

Is this person able to participate in an active camp and/or recreation program? ☐ Yes ☐ No

Any limitations or restrictions while at camp? ☐ Yes ☐ No
If yes, describe:

____

Any medical concerns to be monitored at camp? ☐ Yes ☐ No
If yes, describe:

____

Any meal plans or dietary restrictions to be monitored at camp? ☐ Yes ☐ No
If yes, describe:

____

Date of Physical Exam: __________________________ ***MUST BE WITHIN TWO YEAR OF ATTENDENCE***

I certify that I have completed a physical examination of this person on the date listed above. This person is in satisfactory condition to participate in an active camping or recreation program. I am aware of all medications prescribed to this individual and see no contra-indications. This person can also receive as needed medications and treatments when deemed necessary by Melwood health staff and as outlined in the Melwood Recreation Center standing orders and the Medication form.

Physician's Name (Please Print): ____

Physician's Signature: _______________________________________ Date: ______________

Address: ____

Phone Number: ____________________