RIT National Technical Institute for the Deaf
Health Care Careers Exploration Program

MEDICAL HISTORY

MEDICAL FORM **(To be completed by Physician)**

Student Name: _____

Address: _____

Date of Birth (MM/DD/YYYY):_____M / F (Please circle one)

Please indicate the childhood illnesses the student has had and complete the information about the student's current physical condition. If the student has not had that illness or disease, please check the "NO" box.

CHILDHOOD ILLNESSES	Yes	No	Date	CURRENT PHYSICAL CONDITIONS	Yes	No
Chicken Pox				Asthma		
German Measles				Bleeding/Clotting Disorder		
Measles				Cancer		
Mumps				Convulsions/Seizures		
				Diabetes		
				Frequent Ear Infections		
ALLERGIES				Heart Defect/Disease		
Hay Fever				High Blood Pressure		
Insect Sting Reaction				Kidney Disease		
Penicillin				Lung Disease		
Poison Ivy, Poison Oak, etc.				Vision Impairment		

Does the student have any food/medication/other allergies? If so, please list.

_____

IMMUNIZATION HISTORY

The New York State Department of Health requires a complete immunization history for each student enrolled in the HCCEP program. This information must be completed by the student's physician or nurse practitioner. We also ask that the HCCEP Program Coordinator be notified if the student has been exposed to any communicable diseases in the three weeks prior to the start of the program.

The student cannot be enrolled until we have this information on file.

DTaP (Diphtheria, Tetanus & Pertussis) List dates received	1st	2nd	3rd	4th	5th
HIB (Hemophilus Influenza Type B) List dates received	1st	2nd	3rd	4th	Booster
HB (Hepatitis B) List dates received	1st	2nd	3rd	4th	
Polio (Inactivated oral) List dates received	1st	2nd	3rd	4th	
MMR (Measles, Mumps, Rubella) List dates received	1st	2nd			
Varicella (chicken pox) List dates received	1st	2nd			
Tdap (Tetanus, diphtheria, & pertussis) List dates received	1st	Booster	**TB Mantoux** (Tuberculin skin test) Test given?	☐ Yes ☐ No	Date:

I verify that all immunizations are current for the above named student.

Name of Doctor or Nurse Practitioner _____

Doctor's Address _____

Doctor's Phone Number (REQUIRED) _____

Doctor's Signature (REQUIRED) _____ **Date** _____

5-DAY MEDICATION RECORD

○ **DATE:** July 20 – 25, 2024

Student Name_____ Date of Birth _____ (MM/DD/YYYY)

IT IS HCCEP PROGRAM POLICY THAT, AT CHECK IN, ALL MEDICATIONS MUST BE GIVEN TO HCCEP HEALTH STAFF TO BE KEPT IN A SECURE PLACE MONITORED BY HCCEP HEALTH STAFF OR TEAM LEADERS.

MEDICATION NAME	MEDICAL CONDITION	DOSE	START DATE	END DATE	TIME (am/pm) or with Meal

** If you need more space, please attach additional page. This form is confidential and will be shredded by August 15, 2024. **

All medications must be in their original vial, and must be accompanied by a patient-specific written order from a licensed prescriber. Pharmacy labeling is NOT sufficient.

Medications will **not** be accepted if they are in pill boxes, Ziploc baggies, etc.

OVER-THE-COUNTER MEDICATIONS ARE NOT AVAILABLE AT HCCEP.

Any over-the-counter medications must be prescribed by a doctor with the camper's full name, date of birth and a valid expiration date not to expire before the start of the program and in the original container. Examples of over-the-counter medications include, but are not limited to, Tylenol, Advil, Benadryl, Midol and Tums.

☐ I give permission for the camp medical director to administer medication as dictated by prescription.

Parent/Guardian name (please print) _____

Parent/Guardian signature_____Date _____

Doctor's signature_____Date _____
(REQUIRED)