

# Allenberry Professional Theatre Conservatory

## HEALTH HISTORY AND PRIVATE PHYSICIAN EXAMINATION FORM (Please Print)

Please return completed form to Allenberry Conservatory, PO Box 7, Boiling Springs, PA 17007



Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle Initial

Parent(s) or Guardian(s) \_\_\_\_\_

Home Address \_\_\_\_\_ HomePh. \_\_\_\_\_  
Street & Number City State Zip Code Area Code Number

Second Parent or Emergency Contact (if child does not live with parent) \_\_\_\_\_

Home Address \_\_\_\_\_ Home Ph. \_\_\_\_\_

Operations or serious injuries (including dates) \_\_\_\_\_

Chronic or recurring illness or medical condition \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

Current (send with instructions for use) or recently discontinued medications \_\_\_\_\_

Other diseases \_\_\_\_\_

Has applicant been or is now in any kind of therapy (social worker, psychologist, psychotherapist, psychiatrist or other kind of treatment) for any reason? **(Full disclosure required)** \_\_\_\_\_

Additional notes or comments \_\_\_\_\_

### Health History (Check all that apply and give approximate dates)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Frequent Ear Infections _____     | <input type="checkbox"/> Chicken Pox _____      | <input type="checkbox"/> Insect Stings _____  |
| <input type="checkbox"/> Heart Defect/Disease _____        | <input type="checkbox"/> Measles _____          | <input type="checkbox"/> Drug Allergies _____ |
| <input type="checkbox"/> Convulsions _____                 | <input type="checkbox"/> German Measles _____   | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Diabetes _____                    | <input type="checkbox"/> Mumps _____            | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Bleeding/Clotting Disorders _____ | <input type="checkbox"/> Hay Fever _____        | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Hypertension _____                | <input type="checkbox"/> Asthma _____           | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Mononucleosis _____               | <input type="checkbox"/> Poison Ivy, etc. _____ | <input type="checkbox"/> Other _____          |

### **IMPORTANT --- THIS BOX MUST BE COMPLETED PRIOR TO ATTENDANCE IN THE APTC PROGRAM**

This health history is correct to the best of my knowledge. APTC's representatives have permission to engage in all prescribed activities except as noted. If I cannot be reached in an emergency, I hereby give permission to the physician selected by APTC to secure and administer treatment, including hospitalization, for the person named above. Photocopied forms may be used for trips out of the immediate program location.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_  
Signature Printed Name and Address

I also understand and agree to abide with any and all restrictions placed on my activities.

Signature of minor participant \_\_\_\_\_ Date \_\_\_\_\_

**Immunization History**

Please record the date (month and year) of basic immunizations and most recent booster doses, or "N/A" if the immunization has not been received.

Vaccines		Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) Tetanus	DPT		
Tetanus Diphtheria	TD		
Tetanus			
Oral Polio (Sabin)* TOPV			
Injectable Polio (Salk)			
Measles (hard measles, red measles, rubella)			
Mumps			
Rubella (German measles, 3-day measles)			
Other			
Tuberculin test given _____ (most recent)			
Haemophilus influenza b (HIB)			
Hepatitis B			

**IF THE PARTICIPANT IS CURRENTLY UNDER THE ONGOING CARE OF A LICENSED PHYSICIAN,  
THE FOLLOWING SECTION MUST BE COMPLETED FOR PARTICIPATION IN THE APTC PROGRAM.**

I have examined the above camp applicant within the past two years. Initial \_\_\_\_\_ Date of Examination \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

The applicant is under the care of a physician for the following condition(s) \_\_\_\_\_

Current treatment (include current medications) \_\_\_\_\_

In my opinion, the above condition  does  does not preclude his/her participation in APTC.

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

Does applicant have epilepsy?  Yes  No Does applicant have diabetes?  Yes  No

**Recommendations and Restrictions While attending APTC**

Any treatment to be continued or medication to be administered during the program \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions \_\_\_\_\_

Any allergies (food, drugs, plants, insects, etc.) \_\_\_\_\_

Activities to be discouraged or limited \_\_\_\_\_

Additional Health Information \_\_\_\_\_

**Licensed Physician's Signature** \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street and Number City State Zip Code Area Code Number

Date of Form Completion \_\_\_\_\_ By \_\_\_\_\_

Please initial if completed by nurse or physician's assistant

**Please Print Physician's Name** (Signature required above) \_\_\_\_\_