



HDTU-HDVN HEALTH FORM

Please complete all pages and sign this medical consent form.

Liên Đoàn Name

Participant's Last Name

Middle Name

First Name

Birthdate (mm/dd/yyyy)

Male Female

Email

Phone _____

Home Address

(For minors only)

Name of Parent/Guardian 1

Address (if different from Participant's)

Phone

Name of Parent/ Guardian 2

Phone

Emergency Contact Name

Relationship to Participant

Emergency Contact Phone

INSURANCE / DOCTOR INFO

Health Insurance Co.

Group No.

ID/Policy No.

Name of Primary Care Physician

Phone

List any medications participant is currently taking:

Medication	Dosage	Instruction
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergy

Drug or medication allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type of reaction: _____
Peanut or nut allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type of reaction: _____
Insect bites/stings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type of reaction: _____
Seafood (shellfish, fish, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type of reaction: _____
Pollens/dust?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type of reaction: _____
Others _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type of reaction: _____

Health History

Have you ever been treated for the following?

High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke/TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung/respiratory disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain or angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear/eye/nose problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular heart beat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle or bone issues	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head injury/concussion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric or emotional difficulty	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavioral/neurological disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood disorder/sickle cell	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety or panic attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obstructive sleep apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADHD/ADD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep disorders/sleepwalking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure/epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting spells/dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home sickness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No

Immunization

Tetanus within the past five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pertussis/Diphtheria	<input type="checkbox"/> Yes <input type="checkbox"/> No
Measles/mumps/rubella	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Meningitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No
Influenza	<input type="checkbox"/> Yes <input type="checkbox"/> No	Covid-19 (complete)	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Covid-19 (Booster)	<input type="checkbox"/> Yes <input type="checkbox"/> No

INFORMED CONSENT AND AUTHORIZATION: I understand that participation in camp activities involves the risk of personal injury, including serious injury and death, due to the physical, mental, and emotional challenges in the activities offered. I understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by applicable rules.

In the event of an emergency involving me or my child, I understand that effort will be made to contact the person listed as the emergency contact person by the medical provider and/or by HDTU-HDVN staff. In the event that this person cannot be reached, I give permission to the medical provider selected by HDTU-HDVN staff in charge to secure proper treatment, including anesthesia, surgery, injection of medication for me or child, and hospitalization. I authorize medical providers to disclose protected health information to the adult in charge, camp medical provider, adult leaders, and/or any physician or health-care provider involved in providing medical care to the participant.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name (Print) _____ Relationship _____

Camper Signature _____ Name (print) _____ Date _____

Participant Physical Examination Clearance

Participant Full Name:

Date of Birth (mm/dd/yyyy):

Name of Physician/Nurse Practitioner/Physician Assistant:

Name of Medical Group: _____

Address:

Office Phone Number:

EXAMINATION

Height: _____ **Weight** _____ **Blood Pressure:** _____ / _____ **Pulse:** _____

	Normal	Abnormal	Explanation
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
E/N/T	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Examiner's Certification

I certify that I have reviewed the health history and examined this person. I find no contraindications for participation in this camp. The participant:

- | True | False | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Meets height/weight requirements |
| <input type="checkbox"/> | <input type="checkbox"/> | Does not have uncontrolled heart disease or hypertension |
| <input type="checkbox"/> | <input type="checkbox"/> | Does not have uncontrolled asthma or breathing problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Has not had an orthopedic or musculoskeletal injuries within the past 6 months |
| <input type="checkbox"/> | <input type="checkbox"/> | Has had no seizures in the past 12 months |
| <input type="checkbox"/> | <input type="checkbox"/> | Has no uncontrolled psychiatric disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Does not have poorly controlled diabetes |

Examiner's Signature: _____

Date: _____

Examiner's Printed Name: _____