

PINE ISLAND CAMP
BELGRADE LAKES, MAINE 04918
207-729-7714 (winter); 207-465-3031 (summer)

MEDICAL QUESTIONNAIRE TO BE COMPLETED BY PARENT

Please record below all information of major or minor importance to the health of your son and sign the treatment authorization on the back of this form. **Be sure to get your Family Physician to sign and complete the immunization information on the back of this form**, and then return the form to us at **least two weeks** before your son's arrival at camp.

Date: _____

Boy's name _____ Birthdate: _____ Social Security #: _____

Parent or Guardian _____ Home phone _____

Father's business phone _____ Mother's business phone _____

Home Address _____ Cell phone _____

City _____ State _____ Zip _____

Summer Address _____ State _____ Zip _____

If you are not available, name of alternative emergency contact:

_____ Phone _____

Any surgical operations or injuries: _____

Illness in the past two months: _____

Conditions restricting participation in camp activities: _____

Any matters of psychological importance: _____

Allergies/dietary restrictions (include prescriptions and letter from physician where applicable): _____

Medicines to be taken at camp. (Include physician's letter, times, amounts and what for if not mentioned): _____

Sleepwalking: _____ Bedwetting: _____

Contagious Diseases: (please give age and date) It is of great importance that parents notify Pine Island if a child has been exposed to a contagious disease and could be arriving at camp within the disease's incubation period.

Measles _____	Mumps _____
Chicken Pox _____	Polio _____
Whooping Cough _____	Scarlet Fever _____
Rheumatic Fever _____	Meningitis (type) _____
German Measles _____	Diphtheria _____
Streptococcal Infections _____	Known exposure to HIV _____
Tuberculosis _____	Hepatitis _____
Epstein-Barr virus (mononucleosis) _____	H1N1 ("Swine flu") virus _____

Additional health concerns: _____

(Parents' section of health form continues on reverse --->)

Health Insurance:

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR SON'S HEALTH INSURANCE CARD

Policyholder's Name: _____ Signature: _____

Emergency Information & consent to treat

To the best of my knowledge, this health history is correct and complete, and the camper has my permission to participate in all of the activities referred to in Pine Island promotional and informational materials. I hereby give permission to the camp medical personnel to provide routine medical care to my child in the infirmary. I give permission to the medical personnel selected by the camp director to order treatment, x-rays, routine tests, and necessary transportation for my child. I acknowledge that in case of minor injury or illness, my child will be admitted to the infirmary and I will be notified in all but the most minor cases. In the event that I cannot be reached immediately in an emergency or in case of serious illness or injury, or when delay could cause danger to the camper, I hereby give permission to the physician selected by the camp director to secure and administer any and all treatments or procedures he or she deems necessary, including hospitalization, emergency medical or surgical procedures, and the use of anesthesia. Furthermore, I authorize the release of any and all of my child's medical records as requested by the attending physician. I agree to be responsible for reimbursement of any and all medical expenses incurred by Pine Island Camp on behalf of my child.

Parent or guardian signature: _____ Date: _____

The following section should be completed by the family physician's office
Please complete form below or attach a copy of child's immunization record

VACCINE	DTP	VARICELLA	HIB	OPV	HEP B	MMR 1	MMR 2	TD
<u>Date Given</u>	_____	_____	_____	_____	_____	_____	_____	_____
<u>Date Given</u>	_____	_____	_____	_____	_____	_____	_____	_____
<u>Date Given</u>	_____	_____	_____	_____	_____	_____	_____	_____
<u>Date Given</u>	_____	_____	_____	_____	_____	_____	_____	_____
<u>Date Given</u>	_____	_____	_____	_____	_____	_____	_____	_____

Health concerns or restrictions: _____

Family Physician:

Name: _____ Phone: _____

Address: _____ Date of most recent appointment: _____

Physician's signature: _____ Date: _____

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You must fill out this form ONLY if your son will bring self-administered emergency medication to camp.

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HEALTH CARE PROVIDER PERMISSION FORM

APPROVAL FOR CARRYING AND SELF-ADMINISTERING EMERGENCY MEDICATION AT PINE ISLAND CAMP

As the primary health care provider for (camper's name) _____, I order the carrying and self-administering, as medically necessary, of the following medications by the above-named camper: (Circle all that apply or list other emergency self-medication device.)

- a. Asthma Inhaler
- b. Epinephrine Pen
- c. Other _____

Further, I confirm that this camper has the knowledge and the skills to carry and safely self-administer the indicated emergency medication in camp.

Health Care Provider signature

Date

PARENT PERMISSION FORM

USE OF SELF-ADMINISTERED EMERGENCY MEDICATION AT PINE ISLAND CAMP

As the parent or guardian of (camper's name) _____ I approve of my child carrying and self-administering, as medically necessary, the medications listed above.

Further, I confirm that my child has the knowledge and the skills to safely carry and self-administer the above listed emergency medication in camp.

Parent or Guardian signature

Date

Patient Name/Date of Birth

OR

ID Label/Sticker

MaineGeneral Health: MaineGeneral Medical Center, MaineGeneral Health Associates, MaineGeneral Rehabilitation & Nursing Care, HealthReach Network, and MaineGeneral Retirement Community

Family Medicine Institute, Four Seasons Family Practice, and Maine Dartmouth Family Practice Registration Form

I. General Consent to Treatment and Right to Refuse Treatment

General Consent to Treatment: By signing below, I authorize MaineGeneral Medical Center and its subsidiaries indicated in the heading above (collectively, "MaineGeneral"), their physicians, health care staff, contracted health care providers/agents, and other individuals responsible for providing my medical care, to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating health care provider(s) to explain to me the nature of proposed care, treatment, services, medications, interventions, or procedures, the potential benefits, risks, or side effects, including potential problems that might occur during recuperation, the likelihood of achieving goals, reasonable alternatives, and the relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services, when indicated.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care provider(s), including the right to forgo or withdraw life-sustaining treatment and the right to withhold resuscitative services.

Medical Education and Participation of Students and Trainees: I understand that MaineGeneral is dedicated to medical education, and that authorized, appropriately supervised students and trainees may observe and assist in my diagnosis, treatment and care, unless I expressly object to their participation in my health care.

Use of Videos and Photographs: I understand that video recordings and/or photographs may be utilized in my care for the purpose of diagnosis, documentation, medical education, or performance improvement. However, I understand that my specific, separate consent must be obtained before recordings, films or photographs that reveal identifying information will be made for external purposes, such as marketing, or will be heard or seen by the public.

II. Advance Directives

I understand that I have the right to make decisions about my medical care, including the right to formulate an advance directive documenting the care I wish to receive or refuse in the event that I should lose the capacity to make decisions for myself. I understand that I can document my healthcare preferences in a healthcare instruction, or appoint a person to make decisions on my behalf in the event that I should become incapacitated in a durable power of attorney for healthcare. I understand that I have the right to have my healthcare preferences documented in my medical record, whether or not I have executed an advance directive, and that I have the right to review and revise any advance directives I might already have. I also understand that I will receive further information from MaineGeneral regarding advance directives.

III. Acknowledgment of Responsibility for Payment and/or Assignment of Benefits

By signing below, I understand and acknowledge that I am financially responsible for paying all costs associated with the health care services I receive from MaineGeneral. I understand that I may be financially responsible for such costs even if I have health insurance, depending on the benefits and coverage limitations of my health insurance policy. I understand that I am also financially responsible for charges not covered by my health insurance, including deductibles and co-payments. I understand that health information about me, including (if applicable) information related to HIV/AIDS, substance abuse, and mental health treatment, may be shared with my health insurance carrier(s) or other third party payers responsible for paying for my health care. I understand that I may elect to bear the costs of my care privately if I do not wish certain sensitive health information disclosed to my third party payer.

By signing below, I authorize my health insurance carrier(s) or other third party payers responsible for paying the costs of my health care, including Medicare, MaineCare (Medicaid) and TRICARE, to pay the costs associated with my health care directly to MaineGeneral, its physicians, staff and/or its contracted agents.

Notice of Disclosure of Information When Treatment Is Provided to a Minor: A minor who consents to health care services on his or her own behalf, but whose services are reimbursed under a parent's insurance policy, understands and acknowledges that his or her parent will receive an Explanation of Benefits describing the nature of the services provided and that as a result such services may not be confidential.

IV. Notice of Privacy Practices

I understand and acknowledge that MaineGeneral may use health information about me for purposes of treatment, payment, or health care operations. I understand that MaineGeneral may disclose health information about me, including mental health, substance abuse, and HIV/AIDS-related health information, when authorized by me or when otherwise required or authorized by law. I understand that a detailed list of permissible uses and disclosures is included in MaineGeneral's Notice of Privacy Practices. I understand that a copy of the Notice of Privacy Practices will be made available to me, and that I have the right to review it before signing this form. I understand that copies of the Notice of Privacy Practices are available in patient check-in locations and outpatient areas throughout MaineGeneral and on-line at www.maine-general.org.

By signing below, I acknowledge that I have been offered and have (check box that applies):

- RECEIVED** a copy of MaineGeneral's Notice of Privacy Practices
- REFUSED** a copy of MaineGeneral's Notice of Privacy Practices

I also understand that MaineGeneral may use or disclose limited health information about me to the persons or entities indicated below unless I specifically object to such uses or disclosures. **Accordingly, I agree to the following disclosures except for those I have crossed out or modified (cross out or alter any disclosure you wish to prohibit or restrict):**

- I authorize MaineGeneral to disclose my room number and general health status (e.g., good, fair, stable, serious, critical, etc.) to family members or members of my household.
- I authorize MaineGeneral to disclose my name, room number, home address, and religious affiliation to the hospital chaplain and/or members of the clergy who request this information.
- I authorize MaineGeneral to disclose my name and general health status to members of the media who request this information.
- I authorize MaineGeneral to list my name, room number and general health status in the hospital directory (available to members of the public).

V. Signature

By signing below, I hereby acknowledge that I have read the above information, that I understand and agree to the above statements, and that I have been afforded the opportunity to have any questions I might have addressed.

Signature of Patient or Legally Authorized Representative

Date

If signed by Authorized Representative, state legal authority of person to act on behalf of patient, e.g. healthcare power of attorney agent, healthcare surrogate, guardian, parent of a minor, etc.