



Summer Institute (Grades 6-8)

SI • 2019

Return to Summer Office at:
4525 Union Avenue, San Jose, California 95124
Phone: 408.553.5738 | Fax: 408.553.5735
summerinstituteMS@harker.org | summer.harker.org

Health History Form

****This form is required for all Non-Harker students enrolled in the Middle School Program****

Student's Name: _____ Date of Birth: _____ Age: _____ Grade in Fall: _____

Male Female

Parent/Guardian: _____ Home Phone: () _____

Mother's Work Phone: () _____ Cell Phone: () _____

Father's Work Phone: () _____ Cell Phone: () _____

If not available in an emergency, notify:

Name: _____ Phone: () _____

Name of Pediatrician/Physician: _____ Phone: () _____

Name of Dentist/Orthodontist: _____ Phone: () _____

Medical/Hospital Insurance Carrier: _____

(Attach photocopy of insurance card, if available.)

Group Number: _____ I.D. Number: _____

Is any medication taken at home? _____

Is any medication to be given at camp? _____

Though an emergency is unlikely, if your child requires transportation by ambulance to an emergency room, you may be able to

request a choice of hospitals. Please list the hospital of your choice:

If your child has asthma, please explain what triggers the asthma, and what medication or treatment should be provided:

(Please continue on other side)

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Please note anything to which your child is allergic, what kind of reaction occurs, and what medication or treatment should be provided:

Allergic to:

Reaction:

Medication/Treatment:

Past medical treatment, hospitalizations, serious illnesses or surgery:

Are there any disabilities, physical or emotional, which limit your child's participation in classroom activities, recreation, competitive sports or any other camp activity? Is there anything about your child's health, past or present, you would like to explain?

IMPORTANT - THIS BOX MUST BE COMPLETED FOR ATTENDANCE

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed Summer Institute activities, except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp.

Signature of parent or legal guardian: _____ Date: _____

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor: _____

If for religious reasons you cannot sign this than the camp should be contacted for a legal waiver, which must be signed for attendance.

**YOUR APPLICATION WILL NOT BE PROCESSED WITHOUT
THIS COMPLETED HEALTH RECORD**