Mount Wachusett Community College

Summer Adventures Permission and Contact Information Form

please print clearly

State regulations require we have parental contact information and at least one emergency contact person.

Child's Name (required):

Child is enrolled in (required):

Date of Birth (required):

Parent/Guardian Name (required):

Phone (required):

Email (required):

Second phone contact in case of emergency:

MEDICAL

Are there any legal restrictions on the release of your child or records to a non-custodial parent (required)? **Yes No**

My Child has a food ALLERGY to:

Does your child carry an EpiPen (required)? **Yes No**

If your child has a disability and requires accommodations in order to participate fully in program activities, please contact the **Disabilities Office at 978-630-9120** to discuss specific needs.

Please provide us with any additional information about your child that you think is important or may affect your child's ability to fully participate in the MWCC camp listed above.

PERMISSIONS I hereby allow MWCC to photograph the child listed above for use in any type of media MWCC deems appropriate. This can include, but is not limited to, newspaper stories, printed literature and online information. I hereby give MWCC, its legal representative and assigns, those for whom MWCC is acting, and those acting with its permissions, or its employees, the right and permission to copyright and/or use, reuse and/or publish, and republish, photographic pictures. **I hereby allow MWCC to photograph the child listed above (required): YES OR NO**

PERMISSION AND ASSUMPTION OF RISK AND RELEASE

I give my permission for the child listed above to participate in the selected program(s). I understand that in the unlikely event of an accident, every attempt will be made to contact the person(s) named on form. If unsuccessful, I give my permission to the staff to secure emergency medical services to aid my child, including (if necessary) hospitalization. Any expense arising from the injury or illness is the responsibility of the person signing below. In consideration of being permitted to participate in this program, I, the undersigned in full recognition and appreciation of the dangers and hazards inherent in such activities, which are described in this brochure, during my child's enrollment and/or participation in MWCC activities during this program, do hereby agree to assume all risks and responsibilities surrounding my participation in this program, or activities undertaken as an adjunct thereto; and I assume all risks for injuries and illness; caused by or related to this program; and further I do for myself, my heirs and personal representative hereby defend hold, harmless, indemnify and release, and forever discharge MWCC and all its officers, agents, and employees from and against all claims, demands, and actions, or causes of actions, on account of damage to personal property, or personal injury or death which may result from my participation, and which results from the causes beyond the control of, and without the fault or negligence of MWCC, its officers, agents or employees, during the period of participation. **I give my permission for the child listed above to participate in the selected program(s) (required): YES OR NO**

Parent/Guardian Initials (required):

REGISTRATION IS NOT COMPLETE AND YOUR CHILD(REN) CANNOT ATTEND UNTIL ALL FORMS ARE SUBMITTED.

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name _____ Male Female Date of Birth _____

Medical History _____

Pertinent Family History

Mount Wachusett Community College

Current Health Issues

Y N

☐ ☐ Allergies: Please list: Medications _____ Food _____ Other _____

History of Anaphylaxis to _____ Epi-Pen Yes No

☐ ☐ Asthma: Asthma Action Plan Yes No (Please attach)

☐ ☐ Diabetes Type I Type II

☐ ☐ Seizure disorder: _____

☐ ☐ Other (Please specify) _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:** _____

Hgt:_____(_____%) Wgt: _____(_____%) BMI: _____(_____%) BP: _____

Check = Normal /If abnormal, please describe.)

☐ General_____ ☐ Lunges_____ ☐ Extremities_____

☐ Skin_____ ☐ Heart _____ ☐ Neurologic _____

☐ HEENT _____ ☐ Abdomen _____ ☐ Other _____

☐ Dental/Oral _____ ☐ Genitalia _____

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐

	(Pass)	(Fail)
Hearing: Right Ear	☐	☐
Left Ear	☐	☐

	(Pass)	(Fail)
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: Lead_____ Date _____ Other _____

The entire examination was normal:

Targeted TB Skin Testing: Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries, medical risk factors):

Date of PPD: _____; Results: _____mm.

Referred to evaluation to: _____ Low risk (no PPD done)

This student has the following problems that may impact his/her education experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit

☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations: _____

☐ Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** _____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.**

_____

Signature of Examiner Circle: MD, DO, NP, PA Date *Please print name of Examiner*

_____

Group Practice Telephone

_____

Address City State Zip Code

Please attach additional information as needed for the health and safety of the student

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / / **Sex:** female male

If combination vaccine is administered, please indicate vaccine type (e.g. DtaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		**Haemophilus influenzae type b** (e.g., Hip, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Hepatitis A** (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1			3	
	2		**Other:**		
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:
physician interpretation of parent/guardian description of chickenpox
physical diagnosis of chickenpox, or
serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (please print) **Date:** / /

Signature: _____

Facility name: _____