



CONCORDIA LANGUAGE VILLAGES

2010 VILLAGER HEALTH HISTORY SUMMER YOUTH PROGRAMS

Return by May 1, 2010 to
Concordia Language Villages
901 8th St S
Moorhead, MN 56562

- Having adequate information about your villager is crucial to our ability to provide a supportive environment. We rely on you to tell us what we need to know about your villager.
- Form must be completed and signed by a custodial parent/guardian.
- Our healthcare and leadership staff have access to the information on this form.
- **Keep a copy** of the completed form; notify our health services department of changes in writing.
- **Registering after May 1?** Complete and return this form now.
- Questions? Call health services at 1-800-450-2214.

*** Asthma, Diabetes or Anaphylaxis?**
Complete an additional form available online at www.concordialanguagevillages.org or by calling 1-800-222-4750.

Parent/Guardian please fill in.

Session Code

Village Passport Number

Villager's Name _____
First Middle Last

M F Age: _____ Birth Date: _____
Month Day Year

Returning Villager Yes No

PARENT CONTACT INFORMATION: We will contact you in an emergency or if we have question about your child. Provide the following contact information for us to use during your child's village session:

Custodial Adult A: _____ Custodial Adult B: _____

Relationship to Villager: _____ Relationship to Villager: _____

Preferred Phone: (____) _____ Preferred Phone: (____) _____

Alternate Phone: (____) _____ Alternate Phone: (____) _____

Street Address: _____

City, State, ZIP: _____

Is this address also the villager's address?..... Yes No

Allergies: Check those that apply to this villager.

This villager has no known allergies.

This villager is allergic to this food(s): _____

Causes anaphylaxis? Yes* No

Describe the reaction if this food is eaten and what is done to manage it: _____

This villager is allergic to this medication(s): _____

Causes anaphylaxis? Yes* No

Describe the reaction and how it is managed: _____

This villager is allergic to the following: _____

Causes anaphylaxis? Yes* No

Describe the reaction and what is done to manage it (attach additional information if needed): _____

Nutrition: Our kitchens prepare foods representing a variety of cultures; be sure your villager is ready to explore various foods. We can work with some medically prescribed diets but do not cater to individual food preferences. Call if you have questions about your villager's diet.

This villager eats a regular diet and is prepared to eat foods of different cultures.

This villager is the following type of vegetarian:

- | | |
|--|---|
| <input type="checkbox"/> Semi-vegetarian (no pork or beef) | <input type="checkbox"/> No pork |
| <input type="checkbox"/> Pesco (no pork, beef or chicken) | <input type="checkbox"/> Vegan (no meats, seafood, eggs or dairy) |
| <input type="checkbox"/> Lacto-ovo (no beef, pork, chicken, seafood or fish) | <input type="checkbox"/> Lacto (no meats, fish, seafood or eggs) |
| | <input type="checkbox"/> Ovo (no meats, fish, seafood or dairy) |

This villager needs a gluten-free meal plan.

This villager is lactose-intolerant. Note: our expectation is that the villager self-manages using products such as Lactaid.

Chronic Health Concerns: check those that pertain to this villager and describe how you handle this at home.

This villager has no chronic health concerns and is capable of full participation in the program.

This villager has the following chronic health concern(s):

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma* | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Surgical History of Consequence |
| <input type="checkbox"/> Diabetes* | <input type="checkbox"/> Fainting | |
| <input type="checkbox"/> Other (describe below) | <input type="checkbox"/> Encopresis | |

Information about items above (attach additional information if needed): _____

Immunization History: Provide the month and year for each immunization or attach a copy of your child's clinic/school immunization record. Starred (★) immunizations must be current.

Immunization	Date: Month(s) & Year(s)	Immunization	Date: Month(s) & Year(s)
Tetanus Booster★ (within 10 years)		Varicella (chicken pox)	
MMR (Measles, Mumps, Rubella)★		Haemophilus influenzae	
Polio Series★		Hepatitis B	
Pertussis Booster		Hepatitis A	

If your villager has not been immunized, please explain why and/or attach supporting documentation. _____

Medication: "Medication" is any substance a person takes to maintain and/or improve his or her health and includes vitamins and homeopathic remedies.

- This villager will not take any daily medications while attending the Language Villages.
- This villager will take the following medication(s) while attending the Language Villages. Bring enough of each med to last the entire session. Villagers taking meds for psychiatric reasons should be on the same medication at the same dose for the three months prior to their Village arrival.

Note: ALL medications must arrive in the original, appropriately labeled pharmacy containers (as described in the Parent Handbook).

Name of Medication	Reasons for Taking It	Dose Given & When	Date Started?
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	

The following medications are stocked in the Village health center and are used to manage illness and injury as directed by our medical protocols.

Cross out those your villager should NOT be given.

- | | | | |
|---|------------------------------|----------|-------------------------|
| Acetaminophen (Tylenol) | Diphenhydramine (Benadryl) | Ivy Dry | Triple antibiotic cream |
| Calamine Lotion | Guaifenesin DM (cough syrup) | Nix | Pseudoephedrine |
| Chlorpheniramine Maleate (allergy medication) | Ibuprofen | Tinactin | Silver sulfadiazine |
| Bismuth Tabs (Pepto-Bismal) | Generic cough drops | Senna | Loratadine |

General History: Check "Yes" or "No" for each statement

1. This villager has had chicken pox or has received the varicella immunization Yes No
2. This villager has had mononucleosis ("mono") during the past school year Yes No
3. This villager's hearing is within normal ranges Yes No
4. This villager's sight is within normal ranges or s/he uses corrective lenses to remedy vision Yes No
5. This villager is prepared to fall asleep at night without supports such as reading or listening to music..... Yes No
6. This villager is free of illness, injury or physical challenges that would affect program participation..... Yes No
7. This villager has piercings..... Yes No
 If so, where? Ears Eyebrow Nose Belly Button Tongue Nipple Other: _____
8. For girls: this villager knows about menstruation and/or has a normal menstrual history Yes No
9. This villager has been in countries outside the United States in the past nine months Yes No
 If "True," list the countries and the length of time spent in each on page 3.

Country: _____

Country: _____

Dates: _____

Dates: _____

10. Villager's Physician: _____

Office Phone: (_____) _____

Villager's Orthodontist: _____

Office Phone: (_____) _____

Mental, Emotional and Social Health: Check "Yes" or "No" for each statement. See **Parent Handbook** for more information.

1. This villager has been diagnosed with Attention Deficit Disorder (ADD) or AD/HD Yes No
2. This villager has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder Yes No
3. This villager has an emotional health concern (specify _____) Yes No
4. During the past academic year, this villager has seen or is currently seeing a professional to address mental/emotional concerns Yes No

If "yes" was the answer to any of the four statements above, attach a statement from your villager's professional (e.g., psychiatrist, physician) that addresses the following three things:

- (a) Describes the concern and the villager's management plan (including medication) while in our program;
- (b) Describes the behaviors that will indicate to our staff that your villager needs professional referral; and
- (c) Provides a recommendation for the villager's participation in the Language Villages program.

5. This villager has had a significant life event that continues to affect the villager's life Yes No
If "Yes," please attach written information about the event – death of a loved one, family change, adoption, new sibling, survived a disaster – its impact upon your villager's life, and care tips for the villager's cabin staff. Keep in mind, our staff are generally college students.

Billing Information for Healthcare: Parent/guardians are financially responsible for healthcare given by an out-of-Village provider.

To whom should healthcare bills be sent?

Name: _____

Mailing address: _____

Preferred Phone: (_____) _____

- It is your responsibility to manage your health insurance; our staff may not do this.
- Call your insurance company; determine if your insurance will "work" while your villager is in our program and/or what you need to do should your villager need healthcare.
- Please instruct your villager if your insurance requires a copay.
- We will have you call our pharmacy with your credit card number if we anticipate that a prescription will be needed.

If your villager has health insurance:

Name of person who holds the policy: _____ Birth date of this person: _____

Policy Number: _____ Name of Insurance Company: _____

If appropriate, attach a front and back copy of your child's health insurance card.

When You Aren't Available – If we cannot reach you, provide contact information for other people who know your villager and with whom we can consult. We assume you have spoken to these alternative contacts and they are willing to assist should the need arise.

Alternate contact: _____ Phone: (_____) _____ Relationship to villager: _____

Alternate contact: _____ Phone: (_____) _____ Relationship to villager: _____

What Have We Forgotten to Ask? Provide additional information about your child's health that may have been neglected on this form. We are particularly interested in information that has impact upon your child's ability to fully participate in our program. Attach additional information if needed.

Parent/Guardian Authorization for Healthcare:

This health history is correct and accurately reflects the health status of the villager to which it pertains. The person described has permission to participate in all Village activities except as noted by me and/or the examining physician. I give permission to the physician selected by Concordia Language Villages to order x-rays, routine test and treatment related to the health of my child for both routine healthcare and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with Language Villages staff. I give permission to photocopy this form. In addition, the Language Villages has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of custodial parent or guardian: _____ Date: _____ Relationship to villager: _____

Send this completed Health History to our office **NOW**. Keep a copy to record changes in your villager's health status. We are interested in providing good healthcare to your villager. If having a physician complete the enclosed **Medical Recommendation** would help us do that, please have your physician complete it. Questions? Contact health services by calling 1-800-450-2214 or e-mailing health@cord.edu.



2010 MEDICAL RECOMMENDATION

Parents:

Have your physician or nurse practitioner complete this form if, in your opinion, information from your medical provider gives our program a better understanding of your child's health need(s). We rely on you to make that determination. This form is recommended for participation at the Language Villages.

To Physicians and Nurse Practitioners:

This child has enrolled in a summer residential program of the Concordia Language Villages. The program includes physical activity (i.e., swimming, soccer, volleyball) and takes place in the Minnesota North Woods. Our healthcare staff will use your information to help meet the health needs of the person described. Note that not all healthcare staff are registered nurses; some have only basic first aid skills.

Name of Language Villager _____

Session Code _____
Letters Number

Return this form to:
Concordia Language Villages
901 8th St S
Moorhead, MN 56562

PLEASE PRINT

MD/NP

Name: _____

Office phone: (_____) _____
Area code

Address: _____
City State ZIP

Date this form was completed: _____

This child is under the care of a physician for the following reason(s): _____

Describe the treatment(s) to be continued at the Villages for this child: _____

List prescription medication(s) that this person should take while at the Villages (provide medical order for administration): _____

This person is allergic to: _____

Should exposure occur, how should the allergic reaction be treated? If this is an anaphylactic response, will this child bring an epinephrine device? _____

Describe significant physical findings regarding this villager and/or describe any limitations which may impact the child's participation in our program: _____

These medications, stocked in the Village Health Center, are used to manage illness or injury concerns and dispensed as directed via medical protocols signed by the program's supervising physician. **Cross out** those which are contraindicated for this villager:

- | | | | |
|---------------------|-------------------------|---------------------|-------------------------|
| Acetaminophen | Diphenhydramine | Ivy Dry | Triple Antibiotic Cream |
| Guaifenesin DM | Sore throat drops/spray | Pseudoephedrine | Calamine Lotion |
| Ibuprofen | Nix | Silver Sulfadiazine | Chlorpheniramine |
| Maleate | Kaopectate | Tinactin | Chamomile Tea |
| Generic Cough Drops | Senna | Aloe | Loratadine |

We may have neglected to ask something you feel is needed to adequately address the health needs of this child. If that is the case, please add your comments. Thank you for helping provide a successful Language Village experience for this child!

Your signature: _____ Date: _____