

Health History Form

*for Youth attending Village Weekend Programs
in Bemidji, MN (3 Nights or Less)*

Due at least 4 weeks before program date.

School's Name: _____
 Village Weekend Date: _____
 Language or Program: _____

Villager Name: _____
First Middle Last
 Birth Date: _____
Month Day Year
 Villager Sex: Male Female
 Custodial Adult: _____
First Middle Last
 Preferred Phone: _(_____)_____
 Email: _____

About healthcare for Village Weekend programs:

- A staff member with basic first aid and CPR skill is at the Village when villagers are present.
- The Village is at least 30 minutes from emergency services.
- Villagers should arrive ready to participate in the program. Do not send a sick or injured child. Should your child be unable to participate, you will be called and expected to come for your child.
- Villagers are responsible for taking their own routine medications; the Language Villages does not administer routine medications to villagers. Medications must be brought in their original container.
- Information about your child's health is shared with staff on a need-to-know basis.

Immunization: Date of your child's most recent tetanus immunization: (month & year) _____

Allergy: Is this child allergic to any food or medication? Yes No

If **YES**, name the item and describe the reaction: _____
 Mild/Moderate
 Anaphylaxis Epi pen
 Mild/Moderate
 Anaphylaxis Epi pen

Nutrition: Our kitchens prepare foods representing a variety of cultures; be sure your villager is ready to explore various foods. We work with some medically prescribed diets but do not cater to individual food preferences. Our kitchens are not kosher. If there is a faith-based reason for not eating a particular meat, please communicate that to us by selecting a vegetarian option below. Call if you have questions about your villager's diet.

Does your child need a vegetarian meal plan? (*Checking "Yes" means we will expect your child to eat this meal plan*) Yes No

If **YES**, check what kind of vegetarian plan is needed:

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

This villager is lactose-intolerant. **NOTE:** It is our expectation that the villager self-manages lactose intolerance using products, i.e. Lactaid.

Asthma: Does this child have asthma? Yes No

If **YES**, will your child carry a rescue inhaler during the program? Yes No

If **YES**, what triggers your child's asthma? _____

Medication(s): Does this child take medication on a routine basis? Yes No

Note: The Language Villages does not assume responsibility for your child's medications. This information is requested in case of emergency.

List the medication(s) that your child takes on a *routine* basis:

- a. Medication: _____ Reason for taking this: _____
 b. Medication: _____ Reason for taking this: _____

What Have We Forgotten To Ask? We are particularly interested in information about your child's health that impacts your child's ability to fully participate in our program, please write the additional information on the back of this page. → We may call you prior to the program if further information or clarification is needed.

Emergency Contact: We will call if we have a question about your child's health and/or in an emergency.

Please provide contact information for a custodial adult who will be available via phone while your child is attending our program:

Name: _____ Phone: _(_____)_____

Custodial Adult Authorization

This information is correct and the child described has permission to participate in all program activities except as noted on this form. I understand that the Language Villages has limited healthcare on site and that staff will call the indicated custodial adult (a) in an emergency, (b) if questions about my child's health arise, and/or (c) when my child is unable to continue because of injury or illness. I understand that I will be billed directly for any healthcare received by the local Sanford Clinic/Medical Center, local ambulance service, or other Bemidji provider. I acknowledge that my child is responsible for taking his/her own routine medication(s) and that information on this form will be shared with Language Villages' staff on a need-to-know basis.

Signature of Custodial Adult: _____ Date: _____