

Health Form

FAX: (256) 890-3369



U.S. Space & Rocket Center®
 P.O. Box 070015
 Huntsville, AL 35807

Trainee cannot begin the program unless all forms are completed and required signatures are provided. Please return completed form in the enclosed self-addressed envelope NO LATER THAN FOUR WEEKS PRIOR TO CAMP SESSION DATE Camp may be unable to assure special needs request for health form received after this deadline. Maintain a copy for your records.

■ TRAINEE INFORMATION (PLEASE PRINT)

Trainee: _____
Last First Name MI

Group Name (IF APPLICABLE) _____

Camp Account # _____

Session Date: _____

Age at time of camp: ____ Date of Birth ____/____/____ Sex: ____

Parent's Name: _____

Address: _____
Last First Name MI

City: _____

State: _____ Zip: _____

Daytime Telephone: () _____

Evening Telephone: () _____

Cell Phone Number: () _____

Emergency Contact: _____
Other than parents

Relationship to Trainee: _____

Telephone: () _____

Is trainee covered by health insurance: Yes No

Please attach copy of both sides of insurance card or claim form. List all medical conditions, physical or learning disabilities; and any emotional or behavioral problems. (Attach behavioral plan.)

Medication trainee will require while at camp: _____

ALL prescriptions, over-the-counter medications, vitamins, and herbal products are collected and administered by nursing staff and MUST be in original containers with labels and dispensing instructions in English. Individuals requiring injections should provide medications, syringes and written instructions signed by physician.

Drug Allergies: _____

Food Allergies: _____

Diet Restrictions: _____

Are immunizations up-to-date? Yes No
 If no, please attach an exemption form or explanation.

Date of last tetanus booster: _____

Trainees maintain a vigorous pace from 7 a.m. to 9-10 p.m. During simulator training, individuals may experience up to three G's of gravitational force, strobe or flashing lights or fluid shifts. Persons with cardiac conditions, severe pulmonary dysfunctions, sensory handicaps or chronic illness may not be able to participate fully in the program.

■ AUTHORIZATION FOR MEDICAL TREATMENT MUST BE SIGNED BY PARENT/GUARDIAN

_____ Trainee has my permission to take any over-the-counter medications (listed below) as needed with the exception of _____

_____ while attending this program. I verify that you have my permission to take

_____ Trainee to the nearest medical facility for emergency treatment and I assume responsibility for payment.

X _____

Parent/Guardian or Adult Trainee Signature Date

The following generic medications are stocked in the clinic and dispensed free of charge as needed: acetaminophen, ibuprofen, decongestant, antihistamine, cough suppressant, throat lozenges, motion sickness medication, anti-nausea, anti-diarrheal, milk of magnesia, antibiotic ointment, anti-itch cream, topical oral pain reliever. Should your child require medical attention, you may ask us not to use or disclose any part of your protected health information for the purposes of treatment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved. Your request must state the specific restrictions requested and to whom you want the restrictions to apply. Medical-related questions may be directed to the Nursing Staff at (256)721-7162.

Name: _____

CAMP Account # _____

Session Date _____

