**FORM 1 Student**

Camper Name (First, Middle, Last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Camp: ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

Camp Attending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Camp Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Male ❑ Female Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age on arrival at camp: \_\_\_\_\_\_\_

(Month/Day/Year)

**HEALTH HISTORY 2020**

****

To Parent(s)/Legal Guardian(s): Please follow the instructions below. Attach additional information if needed.

1. Complete pages 1, 2 and 3 of this form (FORM 1)
2. Complete the top of FORM 2 (Student Health-Care Recommendations) and take FORM 1 with FORM 2 to your child’s health-care provider for review and completion.
3. After FORM 2 has been completed and signed by your child’s health-care provider, send FORM 1 and FORM 2 to Double K Retreat & Adventure Center,

PO Box 98, Easton, WA 98925.

**A physical examination MUST have occurred & been dated within the past 12 months of camper’s arrival date at Double K.**

PO Box 98, Easton, WA 98925

Phone: 509-656-2304 director@doublek.org

Student Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City State Zip

Parent/ Guardian with legal custody to be contacted in case of illness or injury:

Relationship

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Phones: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If different from above) Street Address City State Zip

Work Place of 1st Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Place Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City State Zip

Second Parent/ Guardian with legal custody to be contacted in case of illness or injury:

Relationship

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Phones: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Place of 2nd Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Place Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City State Zip

\*Required - Additional contact in event parent(s) /legal guardian(s) can not be reached. (We authorize this person to pick up our student if necessary.)

Relationship

Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Phones: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City State Zip

**Parent/Legal Guardian Authorization for Health Care:**

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care 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 injections, anesthesia, or surgery for this child. I understand the information on this form will be shared on a “need to know” basis with camp staff. I give permission to photocopy this form. In addition, the camp 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.

Relationship

Signature of Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

**Medical Insurance Information:** This student is covered by family medical/hospital insurance □ Yes □ No

***Include a copy of your insurance card, if appropriate; copy both sides of the card so information is readable.***

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company Phone Number: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Restrictions:** □ I have reviewed the program and activities of the camp and feel the student can participate without restrictions.

□ I have reviewed the program and activities of the camp and feel the student can participate with the following restrictions or adaptations.  *(Please describe below.)*

**Diet, Nutrition:** □ This student eats a regular diet. □ This student eats a regular vegetarian diet. □ This student is lactose intolerant. □ This student is gluten intolerant.

□ Other, *Please explain in space*

**Allergies: □** No known allergies. □ This student is allergic to: □ Food □ Medicine □ The environment (insect stings, hay fever, etc.) □ Other

*(Please describe below what the camper is allergic to and the reaction seen.)*

**Immunization History:** We are required to have immunization records on the official form (both attached and available on our website)

Form 1 Student Health History Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

**Do we have permission to access your child’s immunizations records through online portals if available? ❑ Yes ❑ No**

**Photo Permission:** The applicant hereby gives permission for Double K Retreat & Adventure Center to use, without limitation or obligation, photographs or other media that may include the student’s image or voice to promote Double K or share with our publics. No Minor will ever have their name “tagged” by Double K. ***INITIAL HERE \_\_\_\_\_\_\_***

**Transportation Permission**: Double K may elect in the future to offer bus shuttle service to and from Cle Elum / Rosyln area. Does the applicant authorize the student’s transportation to Double K and returning (assuming service is requested by parent/guardian)?

YES / NO *(circle)* Signature of Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication:**

□ This student will not take any daily medications while attending Double K.

□ This student will take the following medication(s) while at camp:

“Medication” is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **Please review camp instructions about required packaging/containers. We require original pharmacy containers with labels which show the student’s name and how the medication should be given. Provide enough of each medication to last each week, one week at a time.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of medication | Date started | Reason for taking | When it is given | Amount of dose given | How it is given |
|  |  |  | Breakfast  Lunch  Dinner  Other time: \_\_\_\_\_\_\_ |  |  |
|  |  |  | Breakfast  Lunch  Dinner  Other time: \_\_\_\_\_\_\_ |  |  |
|  |  |  | Breakfast  Lunch  Dinner  Other time: \_\_\_\_\_\_\_ |  |  |

The following non-prescription medications may be stocked In the camp office and are used on an as needed basis to manage illness and injury. ***Cross out any medications the student should NOT be given. Parent/Legal Guardian INITIAL HERE \_\_\_\_\_\_\_***

Tylenol Triple antibiotic ointment / Neosporin

Gatorade / Sprite Imodium

Sterile Saline Tums

**Prescription Medications**

Adrenalin (Epiephrine – Epi-Pen Jr.)

Inhaler Albuterol

Signature of Custodial Relationship

Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form 1 Camper Health History Camper Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

|  |
| --- |
| **General Health History: Check “Yes” or “No” for each statement. Explain “Yes” answers below.**  Has/does the student: |
| 1. Ever been hospitalized? ❑ Yes ❑ No 11. Had fainting or dizziness? ❑ Yes ❑ No |
| 2. Ever had surgery? ❑ Yes ❑ No 12. Passed out/had chest pain during exercise? ❑ Yes ❑ No |
| 3. Have recurrent/chronic illnesses? ❑ Yes ❑ No 13. Had mononucleosis ("mono") during the past 12 months?... ❑ Yes ❑ No |
| 4. Had a recent infectious disease? ❑ Yes ❑ No 14. If female, has she menstruated...................................... ❑ Yes ❑ No  If no, has she been told about it? …………………… ❑ Yes ❑ No  If so, is menstrual history abnormal? …………… ❑ Yes ❑ No  Has problems with periods/menstruation? ……… ❑ Yes ❑ No |
| 5. Had a recent injury? ❑ Yes ❑ No 15. Have problems with falling asleep/sleepwalking ❑ Yes ❑ No |
| 6. Had asthma/wheezing/shortness of breath? ❑ Yes ❑ No 16. Ever had back/joint problems? ❑ Yes ❑ No |
| 7. Have diabetes? ❑ Yes ❑ No 17. Have a history of bedwetting? ……………………… ❑ Yes ❑ No |
| 8. Had seizures? ❑ Yes ❑ No 18. Have problems with diarrhea/constipation?................. ❑ Yes ❑ No |
| 9. Had headaches? ❑ Yes ❑ No 19. Have any skin problems? ❑ Yes ❑ No |
| 10. Wear glasses, contacts, or protective eyewear? ❑ Yes ❑ No 20. Traveled outside the country in the past 9 months? ❑ Yes ❑ No |
| ***Please explain `Yes" answers in the space below****,* noting the number of the questions. For travel outside the country, please name countries visited and dates of travel. |
| **Mental, Emotional, and Social Health:** **Check "Yes" or "No" for *each statement*** |
| Has the student: |
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ❑ Yes ❑ No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ………………………… ❑ Yes ❑ No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns? ……………… ❑ Yes ❑ No |
| 4. Had a significant life event that continues to affect the camper’s life? ❑ Yes ❑ No  (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) |
| ***Please explain "Yes" answers in the space below****,* noting the number of the questions. Double K may contact you for additional information |
| **Health-Care Providers:** |
| Name of student’s primary doctor(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street City State Zip |
| Name of orthodontist(s): Phone: ( ) |
| Name of dentist(s): Phone: ( )  Date of Last Dental Exam: |

**FORM 2 STUDENT HEALTH-CARE RECOMMENDATIONS by LICENSED MEDICAL PERSONNEL**

**What Have We Forgotten to Ask?** ***Please provide in the space below***any additional information about the student’s health that you think important or that may affect the student’s ability to fully participate in the camp program. ***Attach additional information if needed***



**To Parent(s)/Legal guardian(s): Complete this section and take this form (Form 2) with Form 1 to your child’s health-care provider for review. After completion, mail Form 1 and Form 2 to Double K.**

Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

Dates Attending:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Male ❑ Female Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age on arrival at DK: \_\_\_\_\_\_\_

(Month/Day/Year)

Student home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip

Parent(s)/Legal Guardian(s) phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent(s)/Legal Guardian(s) stop here. Rest of form to be completed by medical personnel.**

**Allergies: □** No known allergies. ***Describe previous reactions*:**

□ To foods (list):

□ To Medications (list):

□ To the environment (insect stings, hay fever, etc. - list):

□ Other allergies (list):

**Diet, Nutrition:** □ Eats a regular diet. □ Has a medically prescribed meal plan or dietary restrictions (describe below):

Weight \_\_\_\_\_\_ lbs Height: \_\_\_\_\_ft \_\_\_\_\_in Blood Pressure \_\_\_\_\_\_/\_\_\_\_\_\_\_

**Medical Personnel: Please review the Student HEALTH HISTORY FORM (Form 1) and complete all remaining sections of this form (Form 2). Attach additional information if needed.**

**Physical exam done today:** ❑ Yes ❑ No (If “no,” date of last physical: \_\_\_\_\_\_\_\_\_\_\_)

|  |  |
| --- | --- |
|  | Month/Day/Year |

ACA accreditation standards specify physical exam within last 12 months.

The following non-prescription medications may be used on an as needed basis to manage illness and injury. **Medical personnel: Cross out those items the student should NOT be given.**

Tylenol

Triple antibiotic ointment / Neosporin

Gatorade / Sprite

Imodium

Sterile Saline

Tums

Inhaler Albuterol

Adrenalin (Epiephrine – Epi-Pen Jr.)

PO Box 98 Phone: 509-656-2304

Easton, WA 98925 e-mail: director@doublek.org

If you answered “Yes” to the question above, what do you recommend? (Describe below – attach additional information if needed.)

Do you feel that the student will require limitations or restrictions to activity while at Double K? □ No □ Yes

I have reviewed the Student Health History Form (Form 1), and have discussed the Double K program with the student’s parent(s)/legal guardian(s). It is my opinion that the student is physically and emotionally fit to participate in an active Double K program (except as noted above).

Name of licensed provider (**please print**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_

Office Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

Telephone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Tx**: The student is undergoing treatment at this time for the following conditions (describe below): □ None

**Medication:** □ No daily medications □ Will take the following prescribed medication(s) while at Double K

(name, dose, frequency - including any over-the-counter meds, describe below):

**MEDICATION DOSE FREQUENCY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other treatments/therapies**: to be continued at Double K(describe below): □ None needed