This section to be completed, signed, and dated by a physician, licensed advanced registered nurse practitioner, or physician assistant:

**HISTORY**

ALLERGIES: ____________________________________________________________

SERIOUS ILLNESS: _____________________________________________________

HOSPITALIZATION: _____________________________________________________

SURGERY: ____________________________________________________________

BEHAVIOR: ___________________________________________________________

SPEECH: ______________________________________________________________

OTHER: ______________________________________________________________

COMMENTS (attach additional page if necessary):

**PHYSICAL EXAMINATION**

HEIGHT: ___________ WEIGHT: ___________ B/P __________________________

E.E.N.T.______________________________________HEART________________________________

TEETH_______________________________________LUNGS________________________________

BACK________________________________________HERNIA_______________________________

COMMENTS (attach additional page if necessary):
PRESCRIPTION MEDICATION

Is the participant on any prescription medication?   YES   NO (Circle one)

If YES, please list medication, dosage, and instructions on separate sheet. Medication must be in original container. Directions on container must match physician’s written orders. Any changes must be authorized and signed by the physician.

IMMUNIZATION CHART**

Must be completed prior to participant's first day of Apple Hill Summer Session.

Please give month, day and year:

DPT or DT:  1. _________________________ 2. _________________________ 3. _________________________
BOOSTERS: 4. _________________________ 5. _________________________

POLIO:  1. _________________________ 2. _________________________ 3. _________________________
BOOSTERS: 4. _________________________ 5. _________________________

MEASLES: ____________________________ RUBELLA: ____________________________
MUMPS: ____________________________ OTHER: ____________________________

COMMENTS:

I certify that this participant has received the immunizations and tests required by State Law (RDS 200:38) for Camp attendance: (5 DPT, 4 ORAL POLIO, MEASLES VACCINE, RUBELLA VACCINE, MUMPS VACCINE).

EXCEPTIONS: _______________________________________________________

** Immunization chart must be completed or participant cannot be admitted to Apple Hill's summer sessions

HEALTH POLICY

Apple Hill's program requires its participants to rehearse daily for between 3 and 4 1/2 hours; to practice individually for between 1 1/2 and 3 hours; to recreate; to function in a facility which has major hills, steps, and bathroom facilities as much as 200 yards from sleeping quarters; and to function daily with vitality, zest, and good community spirit. Further, Apple Hill does not have professional on-site health care or psychological counseling. Emergency health-care is available in Keene, NH at the Cheshire County Medical Center, a fifteen minute drive from Apple Hill.

In your professional opinion, are there any health or other reasons which would prevent the participant whose name is on this form from functioning and flourishing at Apple Hill?    YES        NO (circle one)
If YES, please specify/advise:

Other Remarks (attach additional page if necessary):

Physician's Signature ____________________________  Month __________ Day ______ Year

Physician’s Telephone ____________________________