# Apple Hill Center for Chamber Music

### **DOCUMENTATION OF PHYSICAL EXAMINATION - 2025**

To fulfill requirement by N.H. State Law

NAME:					Gend	Gender:	
	Last			rst	M.I.		
ADDRESS: _	Stroot			City	State	Zip	
		y Year	_ Name of Parent	•	State	•	
		SESS!	ION(S) ATTENDI	NG: I II III IV V	(circle)		
This sec	tion to be co	-	gned, and dated practitioner, or p	• • •	licensed advanced registe int:	ered nurse	
	<u>HEA</u>	ALTH HIST	ORY AND STAT	TEMENT OF H	EALTH STATUS		
Allergies: All	known or susp	ected allergi	ies, including food	allergies and dieta	ry restrictions:		
Exempt activ	ities: Descripti	ion of any ca	mp activities from	which the camper	is exempt from for health rea	usons:	
Pertinent con treatment, or s	ditions: A des	cription of an	ny current physical, derations while at A	mental, or psycho	ological conditions that requi	re medication	
	container. Dire	ections on co	ontainer must match	physician's writte	ge, and instructions. Medica en orders. Any changes must lete page 3 of this form.		

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:

## **IMMUNIZATION CHART**\*\*

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

Please give month, day and year:

i nysician s signature			·	Tear
Physician's Signature			Day -	<u>Year</u>
EXCEPTIONS: ** Immunization char	must be completed or participant	cannot be admitted to Apple	Hill's summe	r sessions
	received the immunizations and and Pertussis; Polio; Hepatitis B;			
COMMENTS/OTHER:				
5 4	l5	•	_	
COVID-19 (not required but strong	gly recommended): 1	2		
VARICELLA: 1.	2			
MMR: 1	2			
HEPATITIS B: 1	2	3.		
4				
POLIO: 1	2	3		
4	5			
	2			

#### Parental permission for medication administration

Parents: Please fill out this form if your child attending AH is under age 18 AND will require prescription medications during their session. Not required for participants age 18 and older.

I,	_ (parent/guardian name) give permission for the authorized staff
of Apple Hill Center for Chamber	r Music to administer the medications, listed below, to my child,
(ch	nild's name) for the duration of my child's stay at the Summer
Chamber Music Camp.	

I verify that my child has taken this medication prior to the start of camp.

The medication will have a prescription label or written order provided by a physician or APRN, current within the past year, that includes the following information:

- -The camper's name
- -The name, strength, prescribed dose, and method of administration of the medication
- -The frequency of administration of the medication
- -The dated signature of the camper's parent or legal guardian or a licensed health care practitioner for orders other than as shown on the prescription label.

A medication order from a parent or legal guardian or a licensed health care practitioner regarding any medication to be administered as needed shall include:

- -The indications and any special precautions or limitations regarding administration of the medication
- -The maximum dosage allowed in a 24-hour period
- -The dated signature of the camper's parent or legal guardian or a licensed health care practitioner for orders other than as shown on the prescription label.

Medication	Dose	Time/method of administration