Apple Hill Center *for* Chamber Music

DOCUMENTATION OF PHYSICAL EXAMINATION - 2027

To fulfill requirement by N.H. State Law

PARTICIPANT: PLEASE COMPLETE THIS SECTION ONLY

NAME: _____ Gender: _____
Last First M.I.

ADDRESS: _____
Street City State Zip

Date of birth: _____-_____-_____ Name of Parent or Guardian(s): _____
Month Day Year

SESSION(S) ATTENDING: I II III IV V (circle)

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

HEALTH HISTORY AND STATEMENT OF HEALTH STATUS

Allergies: All known or suspected allergies, including food allergies and dietary restrictions:

_____
_____
_____

Exempt activities: Description of any camp activities from which the camper is exempt from for health reasons:

_____
_____
_____

Pertinent conditions: A description of any current physical, mental, or psychological conditions that require medication, treatment, or special restrictions or considerations while at Apple Hill:

_____
_____
_____

Medications: Please list any medication (prescribed or over-the-counter), dosage, and instructions. Medication must be in the original container. Directions on container must match physician's written orders. Any changes must be authorized and signed by the physician. **Parents of campers under age 18: Please complete 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 Workshop Session.

Please give month, day and year:

DPT or DT: 1. _____ 2. _____ 3. _____

4. _____ 5. _____

POLIO: 1. _____ 2. _____ 3. _____

4. _____

HEPATITIS B: 1. _____ 2. _____ 3. _____

MMR: 1. _____ 2. _____

VARICELLA: 1. _____ 2. _____

COVID-19 *(not required but strongly recommended)*: 1. _____ 2. _____

3. _____ 4. _____ 5. _____

COMMENTS/OTHER:

I certify that this participant has received the immunizations and tests required by State Law (RDS 200:38) for Camp attendance: (Diphtheria, Tetanus, and Pertussis; Polio; Hepatitis B; Measles, Mumps, and Rubella; and Varicella).

EXCEPTIONS: _____

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

NEW in 2027: Participants under age 18 are required to have this form completed by a physician, licensed advanced registered nurse practitioner, or physician assistant. Participants over age 18 may complete this form themselves and attach their available immunization records.

_____ _____-_____-_____

Physician's Signature **Month Day Year**

_____

Physician's Telephone **Date of exam: _____**

_____ _____-_____-_____

Participant Signature **Month Day Year**

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 Music to administer the medications, listed below, to my child, _____(child'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**

Parent/guardian signature *Date*