Please complete *ALL* sections; incomplete applications will be returned!!

Primary Care Physician's Name:_____ Phone: (_ _)_____

Cardiologist Name:_____ Phone: (__)_____

Cardiac Diagnosis: _____

Cardiac Surgery: _____

Other medical problems (i.e. ADD, asthma, celiac, etc):

_____

_____

Other Specialist's Name: _____Specialty: _____ Phone: (__)_____

Other Specialist's Name: _____ Specialty: _____ Phone: (__)_____

Behavioral / Mental Health Specialist: _____ Phone: (___)_____

In the past 12 months has your child required surgery, procedures or hospitalization?
If yes, please give date(s) and reason(s):

_____

_____

_____

MEDICATIONS? (Please list ALL medications below)

Medication / Strength	Schedule / Directions	Prescriber

Does your child have any allergies?

Allergen (medications, foods, animals, insects, etc)	Reactions* *(be specific with the symptoms, how severe, when they start, etc.)*	Age of Last Reaction

How do you usually manage allergic reactions (medications, ice packs, etc.)? _____

_____

Does your child have any special diet restrictions (vegetarian, celiac, picky eater):

_____

Does your child have any special needs or physical limitations: _____

_____

Does your child have health insurance**?** _____ Yes _____ No _____ Don't Know

Name of Health Insurance Plan: _____Policy Holder: _____

Policy and/or Group Number: _____

Has your child been to an overnight camp before? ____ Yes ____ No

Is your child able to function at his/her age level? ____ Yes ____ No (describe below)

Does your child have any behavioral, developmental or emotional issues (describe below):

_____

_____

Does your child require one-on-one supervision at school / activities? _____ Yes _____ No

Does your child have an IEP or 504 plan at school? _____ Yes _____ No

Please describe: _____

_____

Does your child have any fears? ____ Yes ____ No

What helps when he/she gets scared?_____

_____

Hasbro Children's Hospital
The Pediatric Division of Rhode Island Hospital
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