

HEALTH HISTORY

This Health History Form must be completed by the parent, legal guardian or facility personnel. It must be received in our office with the Application Part 1 and 2 for registration in any Ventures Travel, LLC trip.

Name _____ Date of Birth ____/____/____ Male _____ Female _____
 Last First Middle Initial
 Doctor: _____ (_____) _____
 Name Address City/State/Zip Phone
 MA # _____ Medicare # _____

PLEASE SEND PHOTOCOPIES OF ALL INSURANCE, MA & MEDICARE CARDS

Special Medical Needs: Please check any that apply
 Orthopedic Appliances Gastrostomy (Feeding Tube) Nebulizer B/D's Tracheostomy
 Colostomy / Ileostomy Catheter: Type _____ Other _____
 Diabetes: Insulin Dependent Controlled by diet Blood sugar testing required
 Receives care from licensed nurse on a daily basis

If any of the above are checked, you will be sent a questionnaire requesting more information which must be completed and returned to our office at least 2 weeks prior to check-in.

MEDICATIONS: All medications received for a Ventures Travel, LLC trip **MUST BE IN THEIR ORIGINAL CONTAINERS, PROPERLY LABELED BY A PHARMACIST** with person's name, medication, dosage and times of administration.

NOTE: * ANY NON-PRESCRIPTION (OVER THE COUNTER) MEDS MUST HAVE A WRITTEN ORDER FROM A MEDICAL DOCTOR (M.D.) OR DOCTOR OF OSTEOPTHY (D.O.) Ventures Travel, LLC strongly encourages that any unnecessary medications (such as vitamins) not be sent.

Oral Medication	mg./tablet	# tablets/dose	frequency	8:00A	NOON	4:00P	9:00P	Special Instructions (before, with or in food)

Please check all that apply:
 swallows meds whole crush meds uses oral syringe (please send) uses medicine spoon (please send)

Topical Medications and Treatments: (Please state specific instructions for use of drops, ointments, dressings, treatments, etc.)

BOWEL PROGRAM: Please check and send all of the medications below which may be administered as needed.
 MOM 2nd day without BM Fleets enema if no results from suppository Other: _____
 Bisacodyl Suppository 3rd day without BM Bowel Program Not Applicable _____

Check if individual is subject to the following:
 sunburn frequent colds dizziness/fainting spells constipation menstrual problems
 frostbite bronchitis ear infection diarrhea vaginal infections
 sore throat pneumonia sinus infection nausea/vomiting urinary infections
 skin rash hernia other _____
 must not get water in ears stay out of water _____
 Please comment on the above checked items for treatment given: _____

This Health History is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. Exceptions: _____

Signature of person who has completed this form _____ Date _____ 5/04

IMPORTANT NOTICE!

TO SHORTEN YOUR CHECK-IN TIME:

- 1. BE SURE TO SEND THIS FORM WITH APPLICATION PARTS 1 AND 2 FOR REGISTRATION WITH VENTURES TRAVEL, LLC.**
- 2. IF THERE IS A CHANGE IN APPLICANT'S HEALTH OR MEDICATIONS, CALL THE DIRECTOR/MANAGER AT (952) 852-0107. PLEASE KEEP US UPDATED!**
- 3. WE MUST BE NOTIFIED OF ANYONE WHO HAS HAD SURGERY WITHIN 3 WEEKS PRIOR TO ARRIVAL. PLEASE CALL THE DIRECTOR/MANAGER AT (952) 852-0107 TO DETERMINE CONTINUED ELIGIBILITY.**
- 4. MEDICATIONS MUST BE IN THEIR ORIGINAL CONTAINERS AND PROPERLY LABELED BY A PHARMACIST.**
- * * * NOTE: ANY NON-PRESCRIPTION (OVER THE COUNTER) MEDICATIONS MUST HAVE A WRITTEN ORDER FROM A MEDICAL DOCTOR (M.D.) OR DOCTOR OF OSTEOPATHY (D.O).**
- 5. PERSONS CHECKING IN PARTICIPANTS MUST BE ABLE TO ANSWER QUESTIONS REGARDING THE APPLICANT'S:**
 - A. DIETARY NEEDS**
 - B. HEALTH AND MEDICATION**
 - C. SPECIAL APPLIANCES AND/OR OTHER MEDICAL NEEDS**

THANK YOU!