

Health History and Examination Form

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. This form, except for the "Health Care Recommendations of Licensed Medical Personnel," (pages 3-4) to be filled in by parents/guardians of minors or by adults themselves.

Name _____ Birth date _____ Age at camp _____

Home address _____
Street address City State Zip

Social Security number of participant _____ Gender: _____ male _____ female

Custodial parent/guardian _____ Phone _____

Home address _____
(If different from above) Street address City State Zip

Business address _____
Street address City State Zip

Second Parent/guardian/emergency contact _____

Business address _____
Street address City State Zip

If not available in an emergency, notify:

Name _____

Relationship _____ Phone _____

Address _____
Street address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? _____ Yes _____ No

If so, indicate carrier or plan name _____ Group # _____

Carrier address _____

Name of insured _____ Relationship to participant _____

Social security number of policyholder or insurance ID number _____

Important - These boxes must be complete for attendance

Permission to Provide Necessary Treatment or Emergency Care

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer: _____

Witness _____ Date _____

I also understand and agree to abide by the restrictions placed on my camp activities.

Signature _____ Date _____

Health History from parent/guardian

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Allergies (Medication, Food, Insect Stings, Hay Fever, Animal Dander etc.) Describe reaction and management of the reaction. **Please explain any restrictions to activities (limitations, adaptations needed, etc.)**

Restrictions

The following restrictions apply to this individual:

- | | | |
|--|----------------------------|--------------------------|
| _____ Does not eat red meat | _____ Does not eat pork | _____ Does not eat eggs |
| _____ Does not eat poultry | _____ Does not eat seafood | _____ Does not eat dairy |
| _____ Does not eat nuts (please specify) | _____ Vegan | _____ Other (explain) |

General Questions (Explain "yes" answers below)

Has/does participant:

- | | | | |
|--|-----------|---|-----------|
| 1. Had any recent injury, illness or infectious disease? | yes or no | 16. Ever had problems with joints? | yes or no |
| 2. Have a chronic or recurring illness/condition? | yes or no | 17. Orthodontic appliance being brought to camp? | yes or no |
| 3. Ever been hospitalized? | yes or no | 18. Have any skin problems? | yes or no |
| 4. Ever had surgery? | yes or no | 19. Have diabetes? | yes or no |
| 5. Have frequent headaches? | yes or no | 20. Have asthma? | yes or no |
| 6. Ever had a head injury? | yes or no | 21. Had mononucleosis in the past 12 months? | yes or no |
| 7. Ever been knocked unconscious? | yes or no | 22. Have problem with diarrhea/constipation? | yes or no |
| 8. Wear glasses, contacts or protective eye wear? | yes or no | 23. Have problems with sleepwalking? | yes or no |
| 9. Ever had frequent ear infections? | yes or no | 24. If female, have an abnormal menstrual history? | yes or no |
| 10. Ever passed out during or after exercise? | yes or no | 25. Have a history of bed-wetting? | yes or no |
| 11. Ever been dizzy during or after exercise? | yes or no | 26. Ever had an eating disorder? | yes or no |
| 12. Ever had seizures? | yes or no | 27. Ever had emotional difficulties for which professional help was sought? | yes or no |
| 13. Ever had chest pain during or after exercise? | yes or no | 28. Ever been diagnosed with a heart murmur? | yes or no |
| 14. Ever had high blood pressure? | yes or no | | |
| 15. Ever had back problems? | yes or no | | |

Please explain any "yes" answers, noting the number of the questions. (for more specific health conditions ie., diabetes mellitus, unstable or newly diagnosed asthma, seizure disorders--please provide more specific health information from the physician regarding the condition)

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP							
TD (tetanus/diphtheria)							
Tetanus/Tdap							
Polio							
MR							
or measles							
or mumps							
or rubella							
Haemophilus influenza B							
Hepatitis B							
Varicella (chicken pox)							
BCG							

Which of the following has the participant had?

- _____ Measles
- _____ Chicken Pox
- _____ German Measles
- _____ Mumps
- _____ Hepatitis

TB Mantoux Test
Test Date: _____
Result: _____

Standard Over the Counter/PRN Medications: (meds available in the infirmary/first aid kits or provided by the individual; to be administered at the discretion of RN)

Drug	Dosage	Schedule	Provider Order	Comments
Tylenol	Per label instructions by age/weight	Q 4hr prn for pain or fever > _____	yes / no	
Ibuprofen	Per label instructions by age/weight	Q 6hr prn for pain or fever > _____	yes / no	
Benadryl	Per label instructions by age/weight	Q 6hr prn for pain or fever > _____	yes / no	
Caladryl Lotion	Per label instructions	For insect bites, poison ivy, itching	yes / no	
Hydrocortisone Cream	Per label instructions	Mild skin irritation, poison ivy, insect bites	yes / no	

Note: Standard over the counter medications *cannot* be administered without sign permission from a licensed medical personnel

Prescription Medication Permission-must be signed by MD (please use extra form for additional medication)

1. Date ordered: _____

Name of medication: _____ Dosage: _____

Time of day: _____ Frequency: _____

MD signature/initials

2. Date ordered: _____

Name of medication: _____ Dosage: _____

Time of day: _____ Frequency: _____

MD signature/initials

3. Date ordered: _____

Name of medication: _____ Dosage: _____

Time of day: _____ Frequency: _____

MD signature/initials

4. Date ordered: _____

Name of medication: _____ Dosage: _____

Time of day: _____ Frequency: _____

MD signature/initials

Signature of Licensed Medical Personnel _____
Printed _____
Date _____ Phone Number _____

Health Care Recommendations by *Licensed Medical Personnel*

Camper/Staff Member Name _____

I have examined the above camp participant. Date of last examination _____

BP _____ Weight _____ Height _____

In my opinion, the above applicant _____ **is** _____ **is not** able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

Current treatment at the time of this report includes:

Recommendations and Restrictions at Camp

Treatment to be continued at camp:

Any medications to be administered at camp: Yes _____ (**see page 3**) No _____

Any medically prescribed meal plan or dietary restrictions:

Known Allergies:

Description of any limitations or restriction on camp activities:

Additional information for health care staff at the camp:

Signature of Licensed Medical Personnel _____

Printed _____

Date _____ **Phone Number** _____

Name of Family Dentist/Orthodontist _____ Phone Number _____