

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 Recommendations of Licenses Medical Personnel," 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 _____ Phone _____
Street address City State Zip

Second Parent/guardian/emergency contact _____

Business address _____ Phone _____
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.

Witness _____ Date _____

Health History

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 Describe reaction and management of the reaction. **Medication, Food, Insect Stings, Hay Fever, Animal Dander 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 products
 Other (describe)

Explain any restrictions to activity (i.e.: what cannot be done, what adaptations or limitations are necessary)

General Questions (Explain "yes" answers below)

Has/does participant:

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

Please explain any "yes" answers, noting the number of the questions.

Name of family physician _____ Phone _____

Name of family dentist/orthodontist _____ Phone _____

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

Medications to be administered at camp

(found on the chart on the next page)

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** _____

INDIVIDUALIZED ORDER FOR: _____

Prescription Medications (Please complete with patient's current regiment for both scheduled and PRN medications).

Drug	Dosage	Schedule	Comments

Standard Over the Counter/PRN Medications (meds available in the Infirmiry/First Aid Kits; 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	
Robitussin	Per label instructions by age/weight	Q 4hr for cough	yes / no	
Pepto-Bismol	Per label instructions by age/weight	Q 30 min to 1 hour prn for diarrhea	yes / no	
Children's Mylanta	Per label instructions by age/weight	BID-TID prn for stomach upset	yes / no	
Dimetapp	Per label instructions by age/weight	Q 6-8 hr prn for nasal congestion/drainage	yes / no	
Benadryl	Per label instructions by age/weight	Q 6 hr prn for allergic reaction (insect bites/hives)	yes / no	

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							
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: _____

Signature of Licensed Medical Personnel _____ Printed _____	Title _____
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