

Camp Health History and Examination Form Dates of Camp Attendance _____

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. **ENSURE THAT ALL SIGNATURE BOXES ARE COMPLETE**

Camper/Staff 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 _____ **Email 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/guardian or adult camper/staffer

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

Witness _____ Date _____

Health History (Please Print Clearly or Type)

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.**

GENERAL QUESTIONS, Explain any yes question below. Has/does the participant:

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

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

Name of family physician _____ Phone _____

Address _____ City State Zip _____

Name of family dentist/orthodontist _____ Phone _____

Address _____ City State Zip _____

Health Care Recommendations by Licensed Medical Personnel (MUST BE SIGNED At Bottom)

Camper/Staff Member Name _____

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

BP _____ Weight _____ Height _____ Temp _____

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 (Please be specific. Include type, and schedule)

Medications to be administered at camp (**Each medication must be listed on Chart on page 4 Individual Orders**)

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 Name and License Number _____

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 Infirmary/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	
Insect Repellent	Per label instructions by age/weight	As needed	yes / no	
Calamine Lotion	Per label instructions by age/weight	As needed	yes / no	

IMMUNIZATIONS--Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Which of the following has the participant had? _____ Measles _____ Chicken Pox _____ German Measles _____ Mumps _____ Hepatitis TB Mantoux Test Test Date _____ Result: _____	
DTP									
TD (tetanus/diphtheria)									
Tetanus									
Polio									
MMR									
or Measles									
or Mumps									
or Rubella									
Haemophilus influenza B									
Hepatitis B									
Varicella (chicken pox)									
BCG									

Signature of Licensed Medical Personnel _____

Printed _____ License # _____