For office use

Health History and Examination Form For Children, Youths and Adults Attending Camps

Sessions attending ☐ 4 weeks ☐ 3 weeks ☐ 7 weeks

Mail this form to the address below by _____

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. The first three pages must be filled out by the parents or guardians of minors or by adults themselves. An update is required annually. The health exam on the last page must be completed by licensed medical personnel at least every two years.

Year

Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address _____
Street City State Zip

Social Security number _____

1st Parent _____ 2nd Parent _____

Address _____ Address _____

_____ _____

Home phone _____ Home phone _____

Work phone _____ Work phone _____

Cell phone _____ Cell phone _____

E-mail _____ E-mail _____

Cabin or group

Insurance Information

▶ A photocopy of the front and back of the health insurance card must be attached to this form.

Carrier or plan name _____ Group # _____

IMPORTANT. These boxes must be completed for attendance.*

To the best of my knowledge, this health history is correct and complete. The person named above has permission to engage in all camp activities, except as noted.

I hereby give my permission to the camp to provide, seek and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child as may be necessary, including, but not limited to, x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person named above is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b) to the disclosure to camp representatives of the protected health information of the person named above, as necessary; (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physican selected by the camp 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 _____

Printed name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer _____ Date _____

Name

* If for religious reasons, you cannot sign this form, contact the camp for a legal waiver, which must be signed for attendance.

Health History

The following information must be filled in by the parent/guardian, adult participant or staff member. It is intended to provide camp personnel with sufficient 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 the participant's arrival at camp.

▶ **It is important to provide complete information so that the camp can respond correctly to your child's/your needs.**

Allergies

List all known	Describe reaction and management of the reaction.
Medication allergies	
Food allergies	
Other allergies (include insect stings, hay fever, asthma, animal dander, etc.)	

Medications

Please list all medications, including over-the-counter or non-prescription drugs, that are taken routinely. Bring enough medication to last the entire camp session. If using a prescription drug, please keep in the original packaging or labeled bottle that identifies the prescribing physician, the name of the medication, the dosage and the frequency of administration.

☐ This person takes no medications on a regular basis.

☐ This person takes the following medications:

Medication _____ Dosage _____ Frequency _____

Reason for taking _____

Medication _____ Dosage _____ Frequency _____

Reason for taking _____

Medication _____ Dosage _____ Frequency _____

Reason for taking _____

▶ Attach additional pages for more medications.

▶ Identify any medications taken during the school year that the participant does/may not take during the summer:

_____

Restrictions

The following restrictions apply to this participant:

Dietary

☐ 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 _____

_____

Activity

Explain what cannot be done or needs to be adapted or limited for this participant:

_____

_____

_____

General Questions

Explain 'yes' answers below.

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

Please explain any 'yes' answers, noting the number of the question(s):

_____

_____

_____

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken pox
- ☐ German measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

TB Mantoux Test

Date of last test _____

Result: ☐ Positive ☐ Negative

Please give all dates of immunization for:

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diptheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
MMR	_____	_____	_____	_____	_____	_____
or Measles	_____	_____				
or Mumps	_____	_____				
or Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Varicella (chicken pox)	_____	_____				

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware:

_____

_____

_____

_____

_____

Name of family physician _____ Phone _____

Address _____

Street City State Zip

Name of participant's dentist/orthodontist _____ Phone _____

Address _____

Street City State Zip

Health Care Recommedations by Licensed Medical Personnel

I examined _____ on _____

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:

_____

_____

_____

Recommendations and Restrictions at Camp

Treatment to be continued at camp: _____

_____

_____

Medications to be administered at camp (name, dosage, frequency): _____

_____

_____

Any medically-prescribed meal plan or dietary restrictions: _____

_____

_____

Known allergies: _____

_____

_____

Description of any limitation or restriction on camp activities: _____

_____

_____

Additional information for health care staff at the camp: _____

_____

_____

Signature of Medical Personnel

Signature _____ Date _____

Name printed _____ Title _____

Address _____ Phone _____

Street City State Zip

For camp use only

Screening Record

Date screened _____ Time _____

Meds received: _____

_____

Updates/additions to health history noted ☐ Yes ☐ No ☐ None required

Current health needs: _____

_____

Notes: _____

_____

Screened by: _____