

For Office Use Only 5/07

# Health History and Examination Form

Due PRIOR to arrival at camp every summer.

H MA FA/R

C/R M PRN

Health history, pages 1-3, must be filled out by parents/guardians of minors, or by adult staff, annually. A Health Exam Form must be completed by approved licensed medical personnel every year. You may use page 4 or attach a current school sports physical form. **Please attach a copy of participant's health insurance card (front and back).**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age at camp \_\_\_\_\_  
Last First

Home Address \_\_\_\_\_  
Street Address City State Zip

Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Business Address \_\_\_\_\_  
Street Address City State Zip

Work Phone \_\_\_\_\_

Is the participant covered by health insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, insurance company: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Insured Person's date of birth \_\_\_\_\_

**(Please attach a photo copy of your health insurance card, front and back.)**

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address City State Zip

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

G  
K  
S  
First Name  
Last Name

First Name

**Medication allergies**

**Describe reaction and management of the reaction.**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Food allergies or Restrictions**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Other allergies - include seasonal, asthma, insects**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Activity Restrictions :** \_\_\_\_\_

**Has/does the participant:**

**Yes**

**No**

**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 eye wear?.....
- 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 any 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. Have a history of bedwetting? .....
- 26. Ever had an eating disorder? .....
- 27. Ever had emotional difficulties for which professional help was sought?

**Please explain any "yes" answers.**

\_\_\_\_\_  
\_\_\_\_\_

Last Name

**Additional information about the participant's behavior and physical, emotional, or mental health of which the camp should be aware.**

\_\_\_\_\_  
\_\_\_\_\_

**Medications Being Taken**

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. All medications must be controlled by the camp infirmary for participants under the age of eighteen.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med#1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

**This person will bring the following to camp: (please circle)**

**Epi Pen            Inhaler            Refrigerated Meds**

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

\_\_\_\_\_

Name of physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**Parent/Guardian Authorization: This health history is correct and complete to the best of my knowledge. The person described has permission to engage in all camp activities except as noted.**

**I hereby give permission to the personnel selected by the Camp Director to provide routine health care, administer prescribed medications, and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.**

**In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. I do hereby indemnify and hold harmless the persons who act in reliance upon this authorization. I further agree to reimburse the provider for the cost of rendering services. This completed form may be photocopied for trips out of camp.**

Signature of parent/guardian or adult staff \_\_\_\_\_

Printed name \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of camper/staff \_\_\_\_\_ Date \_\_\_\_\_

# Health Exam Form: For Licensed Medical Personnel

I examined \_\_\_\_\_ on \_\_\_\_\_.

Name \_\_\_\_\_ Date \_\_\_\_\_

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:

\_\_\_\_\_  
 \_\_\_\_\_

**Which of the following has the participant had?**

**Please give all dates of immunization for:**

**Vaccine:            Dates:    Mo/Yr   Mo/Yr   Mo/Yr   Mo/Yr   Mo/Yr   Mo/Yr**

<input type="checkbox"/> Chicken Pox	DTP	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German Measles	TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis- Type _____	Tetanus	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Measles	Polio	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	MMR	_____	_____	_____	_____	_____	_____
	or Measles	_____	_____	_____	_____	_____	_____
	or Mumps	_____	_____	_____	_____	_____	_____
	or Rubella	_____	_____	_____	_____	_____	_____
TB Mantoux Test- if indicated	Haemophilus Influenza B	_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B	_____	_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (chicken pox)	_____	_____	_____	_____	_____	_____

## 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 or information for camp staff.**

\_\_\_\_\_  
 \_\_\_\_\_

**Signature of Licensed Medical Personnel** \_\_\_\_\_

**Printed** \_\_\_\_\_ **Title** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Date** \_\_\_\_\_