

For Office Use Only 5/10

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). Mail at least pages 1-3 by May 1st**

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

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 _____

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

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

Name of physician _____ Phone _____

City and State _____

Name of dentist/orthodontist _____ Phone _____

City and State _____

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** _____