

2010 CAMPER HEALTH EXAMINATION FORM



Camper Name: _____ Male Female Birth Date: _____ Age at Camp: _____
 Home Address: _____ City/State/Zip: _____ Home Phone Number: _____
 Parent Name: _____ Work Phone Number: _____ Cell Phone Number: _____
 Parent Name: _____ Work Phone Number: _____ Cell Phone Number: _____

IN THE CASE A PARENT CAN NOT BE REACHED, PLEASE CONTACT:

1. Name: _____ Phone: _____ Relationship: _____
 2. Name: _____ Phone: _____ Relationship: _____
 Pediatrician Name: _____ Phone: _____
 Pediatrician Address: _____
 Dentist/Orthodontist Name: _____ Phone: _____
 Dentist/Orthodontist Address: _____

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY)

Name of Contract Holder: _____ Relationship to Camper: _____
 Carrier Name: _____ Carrier Address: _____ Insurance ID Number: _____
 Certificate Number: _____ Group or Policy Number: _____ If Blue Cross: BC of (City) _____

PARENT'S OR GUARDIAN'S CONSENT

- The information provided on this form is correct and complete as far as I know, and my child has permission to engage in all camp activities except as noted.
- I hereby authorize the camp director or camp medical staff to act on my behalf according to their best judgment. I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests or treatment, to arrange necessary related transportation for my child and to release any records necessary for insurance purposes. 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, anesthesia or surgery for my child. This completed form may be photocopied for trips out of camp.
- I hereby authorize the release of any information in connection with this form that the hospital or physician in their sole discretion may deem proper.
- I hereby authorize payment of medical benefits to the camp's designated physician, provider or hospital for services described herein.

Insurance Certificate Holder Signature _____ Date _____
 Parent or Guardian Signature _____ Date _____

HEALTH HISTORY (General Questions – Explain "Yes" Answers Below)

Has/Does the camper:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious diseases?	<input type="checkbox"/>	<input type="checkbox"/>	14. Ever had problems with joints (knees, ankles, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have an orthodontic appliance brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	16. Have any skin problems (itching, rash, acne, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had any serious injuries?	<input type="checkbox"/>	<input type="checkbox"/>	19. Had mononucleosis within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	20. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have problem with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever been dizzy or passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	22. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever had seizures or other epileptic symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	23. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had heart trouble?	<input type="checkbox"/>	<input type="checkbox"/>	25. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had back trouble?	<input type="checkbox"/>	<input type="checkbox"/>	26. Other?	<input type="checkbox"/>	<input type="checkbox"/>

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

(OVER)

CAMPER HEALTH HISTORY (continued)

NAME: _____

MENTAL, EMOTIONAL AND PSYCHOLOGICAL HEALTH

Has/Does the camper:		Yes	No			Yes	No
1.	Has an emotional health concern that will impact camp participation?	<input type="checkbox"/>	<input type="checkbox"/>	3.	Has a significant life event that continues to affect the camper's life/health?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder?	<input type="checkbox"/>	<input type="checkbox"/>	4.	Uses an individualized learning plan at school?	<input type="checkbox"/>	<input type="checkbox"/>

If "yes" was the answer to any of the four statements above, attach a statement from your child's professional (e.g., physician, psychiatrist, therapist) that addresses the following with regard to your child's participation at camp:

- Describes the concern and the camper's management plan (including medications) while at camp;
- Describes the behaviors that will indicate to our staff that your camper needs professional referral; and
- Provides a recommendation from this professional supporting your child's participation in our camp program.

PLEASE NOTIFY US IF CAMPER HAS BEEN EXPOSED TO ANY CONTAGIOUS DISEASES DURING THE 3 WEEKS BEFORE THE START OF THE CAMP SESSION.

Which of the following Measles Chicken Pox German Measles Mumps Hepatitis Sinusitis Bronchitis Rheumatic Fever has camper ever had:

PLEASE GIVE DATES OF MOST RECENT IMMUNIZATIONS FOR:

DTP _____	Polio _____	Haemophilus Influenza B _____
TD (Tetanus/Diphtheria) _____	Measles _____	Hepatitis B _____
Tetanus _____	Rubella _____	

MEDICATION ALLERGIES (list and describe reaction and management of the reaction): _____

FOOD ALLERGIES (list and describe reaction and management of the reaction): _____

OTHER ALLERGIES (list and describe reaction and management of the reaction) – include bee or other insect stings, hay fever, asthma, animals, etc.: _____

MEDICATIONS – Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Include the name of medication, the dosage and frequency of administration. _____

RESTRICTIONS – Please list dietary restrictions, specific activities to be avoided, or necessary adaptations or limitations: _____

FOLLOWING MUST BE COMPLETED BY LICENSED MEDICAL PERSONNEL

I have examined the above listed 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:

Any medications to be administered at camp (name, dosage, frequency) or medically-prescribed dietary restrictions: _____

Any known allergies: _____

Description of limitation or restriction on camp activities: _____

Signature of Licensed Medical Personnel: _____ Date: _____

Printed Name: _____ Title: _____

Address: _____

City, State, Zip: _____ Phone: _____