

Health History & Examination Form 2012



CAMP WINDHOVER
Summer Camp for Youths
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The information on this form is not part of the camper/staff acceptance process, but is gathered to assist us in identifying appropriate care. This form, except for the "Health Recommendations of Licensed Medical Personnel," is to be filled in by parents / guardians of minors or by adults themselves.

I. Camper Information

Camper Name _____
Age on June 1: _____ Gender: Male / Female Social Security # _____
Date of Camper's birth _____
Custodial Parent / Guardian Name(s) _____ Phone(____) _____
Home Mailing Address _____
Business Phone(____) _____
Second Parent / Guardian / Emergency Contact _____ Phone(____) _____
Home Mailing Address _____
Business Phone(____) _____

II. Insurance Information- Attach photocopy of insurance card

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 policy holder or insurance ID number:

III. Parent / Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. 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 to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Parent / Guardian / Staffer

Signature _____ Date ____/____/____

Printed Name _____

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

Minor Camper / Staffer

Signature _____ Date ____/____/____

Printed Name _____

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

IV. Health History

The following information must be filled in by the parent/guardian, or staff member. The intent is to provide camp health care personnel the background information to give 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 camper's or your needs.

Allergies List all known. Describe reaction and management of the reaction.

Medication allergies (list)

Food allergies (list)

Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

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.

_____ 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:

(Attach additional pages for more medications.)

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

Restrictions

The following restrictions apply to this individual.

Dietary

___ Doesn't eat red meat ___ Doesn't eat pork ___ Doesn't eat eggs

___ Doesn't eat poultry ___ Doesn't eat seafood ___ Doesn't eat dairy products

Other (describe) _____

Explain **any restrictions** to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

General Questions (Explain "yes" answers below.)

Has / does the participant: (Please circle)

	Yes	No
1. Had any recent injury, illness or infectious disease?	Yes	No
2. Have a chronic or recurring illness / condition?	Yes	No
3. Ever been hospitalized?	Yes	No
4. Ever had surgery?	Yes	No
5. Have frequent headaches?	Yes	No
6. Ever had a head injury?	Yes	No
7. Ever been knocked unconscious?	Yes	No
8. Wear glasses, contacts or protective eye wear?	Yes	No
9. Ever had frequent ear infections?	Yes	No
10. Ever passed out during or after exercise?	Yes	No
11. Ever been dizzy during or after exercise?	Yes	No
12. Ever had seizures?	Yes	No
13. Ever had chest pain during or after exercise?	Yes	No
14. Ever had high blood pressure?	Yes	No
15. Ever been diagnosed with a heart murmur?	Yes	No
16. Ever had back problems?	Yes	No
17. Ever had problems with joints disease? (e.g., knees, ankles)?	Yes	No

Family physician _____ Phone(____) ____ - ____
Address _____
Name of family dentist / orthodontist _____ Phone(____) ____ - ____

Health Care Recommendations by Licensed Medical Personnel

Submit this page to your pediatrician

I examined _____ (individual's name)
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:

Current treatment at the time of this report includes

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 Licensed Medical Personnel _____

Printed Title _____

Address _____ Date ____ / ____ / ____

Phone(____) _____

For camp use only:

Screening Record

Date screened ___/___/___ Time __:__ am / pm

Meds received _____

Updates / additions to health history noted Yes No None required

Current health needs identified _____

Observational notes _____

Screened by _____

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