Name of Camper/Staff Member: ____DOB_______________

Health History and Examination Form for Campers and Staff Members

There are two parts to this form. Part I is to be filled out by parents, guardians or staff members ONLY. Part II is to be filled out by licensed medical personnel ONLY. The information on this form is not used to determine admittance into our program. It is used to determine appropriate care for your child; however, if it is not adequately or completely filled out, we are bound by ACA regulations and by state law to forbid entrance of the camper or staff member. Please complete this form carefully.

Part I: To be Completed by Parent/Guardian or Staff Member

Personal Information and Medical History

NAME OF CAMPER/STAFF MEMBER: ____DOB ________

Home Address: ____

____Home Phone #: _________________________________

Camper/Staff Member Soc. Sec. Number: ______________________ Age at Camp: ________ Gender: Male _____ Female ____

CUSTODIAL PARENT/GUARDIAN(S): ____

Home Address (if different): ____

____

Home Phone: ________________________ Work: __________________________ Cell: ___________________________

EMERGENCY CONTACT: ____

Relationship to Camper/Staff Member: _____________________ Home Phone__________________ Work: ______________

Address: ____

INSURANCE INFORMATION: Is this person covered by a family medical and/or hospital insurance plan? Yes ____ No ____

If so, Carrier Name: ___________________________________ Group Number: ____________________________________

Carrier Address: ____

Name of Insured: _____________________________________ Relation to Camper: __________________________________

Social Security Number of policy holder, or insurance ID number: ____

PLEASE ATTACH A COPY OF BOTH FRONT AND BACK OF THE CAMPER'S INSURANCE CARD

ALLERGIES

The following information must be filled in by the parent/guardian or staff member. Please keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon the camper's arrival in camp.

MEDICATION ALLERGIES	Please note the date of the most recent reaction and describe reaction and management/treatment of the reaction:
FOOD ALLERGIES	
OTHER ALLERGIES (e.g. insect stings, hay fever, animal dander)	

Name of Camper/Staff Member: ____DOB_______________

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MEDICATIONS BEING TAKEN

Please list all medications (prescription and over-the-counter) currently being taken:	Please list the name(s) of the physician(s) prescribing this medication and provide his/her phone number. For each medication listed, describe the dosage and time to be taken and explain the reason this camper takes this medication:

GENERAL QUESTIONS - Has or does the participant:

1. Had any recent injury, illness, or infectious disease? Yes No	17. Ever had problems with joints (knees, ankles?) Yes No
2. Have a chronic or recurring illness or condition? Yes No	18. Have an orthodontic appliance being brought to camp? Yes No
3. Ever been hospitalized? Yes No	19. Have any skin problems? Yes No
4. Ever had surgery? Yes No	20. Have diabetes? Yes No
5. Have frequent headaches? Yes No	21. Have asthma? Yes No
6. Ever had a head injury? Yes No	22. Had mononucleosis in the past 12 months? Yes No
7. Ever been knocked unconscious? Yes No	23. Had problems with diarrhea or constipation? Yes No
8. Wear glasses, contacts, or protective eye wear? Yes No	24. Have problems with sleepwalking? Yes No
9. Ever had frequent ear infections? Yes No	25. If female, have an abnormal menstrual history? Yes No
10. Ever passed out during or after exercise? Yes No	26. If female, has started menses? Yes No
11. Ever been dizzy during or after exercise? Yes No	27. Have a history of bed-wetting? Yes No
12. Ever had seizures or other neurological conditions? Yes No	28. Ever had an eating disorder? Yes No
13. Ever had chest pain during or after exercise? Yes No	29. Current or reoccurring emotional or psychosocial difficulties for which professional help was sought? Yes No
14. Ever been diagnosed with a heart murmur? Yes No	30.Ever had frequent or recurring urinary tract infections? Yes No
15. Ever had high blood pressure? Yes No	31. Have any limitations on or restrictions of activities at camp? Yes No
16. Ever had back problems? Yes No	

Please explain any "Yes" answers to these questions, noting the number of the question.

____
____
____
____
____
____

Name of Camper/Staff Member: ____DOB________________

Health History and Examination Form for Campers and Staff Members

Part II: To be Completed by Physician

Please give all dates of immunization for:

Vaccine:	**Mon/ YR**	**Mon/ YR**	**Mon/ YR**	**Mon/ YR**	**Mon/ YR**	**Mon/ YR**
DTP						
TD (Tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemophilus influenza B						
Hepatitis B						
Varicella (chicken pox)						
TB/ MANTOUX TEST _______ positive ____ negative						
Meningococcal meningitis						
H1N1 (swine flu)						

Which of the following has the participant had?

Measles
Chicken Pox
German Measles
Mumps

Hepatitis A
Hepatitis B
Hepatitis C

Health Care Recommendations by Licensed Medical Personnel

Please note: ACA regulations require a health examination within 24 months of camp attendance.

I examined this individual on ________________ . In my opinion, the above camper is is not able to participate in camp programs.

BP ____________________ Weight: ________________ Height: ________________

The applicant is under the care of a physician for the following conditions:

____

____

The following treatment(s) should be continued at camp [prescription medications and/or over-the-counter]:

____

____

Any medically prescribed meal plans or dietary restrictions? Yes No

If Yes: ____

____

Any limitations on, or restrictions of, activities at camp? Yes No

If Yes:____

____

SIGNATURE OF LICENSED MEDICAL PERSONNEL: ______________________________________

PRINTED: ____**Title:** ______________

Telephone Number: ______________________________ **Pager/Ans. Service:** ______________________

Address: ____

Name of Camper/Staff Member: ____DOB_______________

Health History and Examination Form for Campers and Staff Members

Standard Over the Counter Medications – The following medications are available in the Health Center and will be administered at the discretion of the Health Director. Please select which medications below can be administered.

*Key: **PRN**(if needed) **PO**(taken by mouth) **Topical** (applied to skin) **Q**(every)*

Drug Name	Route	Dosage	Schedule and Indications	Please mark the box if your child CANNOT use this medicine.	Comments
Acetic Acid Solution	Otic (liquid)	Per label instructions	PRN – Swimmers ear		
Advil Cold & Sinus	PO (pills)	Per label instruction by age/weight	Q 4-6 hrs PRN Pain, fever, nasal congestion		
Anti acid (Mylanta or Tums)	PO (pills or liquid)	Per label instruction by age/weight	Q 2-4 hrs PRN-Gas, heartburn, indigestion, stomach upset		
Antifungal Cream/spray	Topical (cream or spray)	Per label instructions	PRN Athletes foot, jock itch		
Antiseptics (Alcohol) Peroxide, Dermal scrub, Bacitracin)	Topical (cream or liquid)	Per label instructions	PRN-Stings/bites, cuts, scrapes, splinters, blisters		
Benadryl	PO (elixir, chewable tabs or pills)	Per label instruction by age/weight	Q 6 hrs PRN for allergic reaction (hives, insect bite)		
Betadine **(contains Iodine)**	Topical (liquid)	Per label instructions	PRN cuts, scrapes, splinters, blisters		
Caladryl, Calagel and Hydrocortisone	Topical (cream)	Per label instructions	Q 6-8 hrs PRN Rash, Skin irritation		
Calamine	Topical (cream or gel)	Per label instructions	PRN Insect bites, skin irritation, rash		
Cooling gel and Aloe	Topical (cream or gel)	Per label instructions	PRN Burns, sunburn, wind burn		
Cough drops and Lozenges	PO (lozenges)	Per label instruction by age/weight	PRN Coughs, sore throat s		
Dimetapp	PO (elixir or tabs)	Per label instruction by age/weight	Q 6-8 Hr PRN for nasal congestion/drainage		
Dramamine	PO (chewable tabs)	Per label instruction by age/weight	Q 6-8 hrs PRN for motion sickness		
Dyherahydramine	PO/Topical (Pills, liquid or spray)	Per label instruction by age/weight	PRN – Insect bites, allergies, respiratory allergies		
Earcare	Topical (liquid)	Per label instructions	Q 6 hrs PRN Pierced ear infections		
Ibuprofen	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN for pain, fever, cold symptoms, toothache, muscle aches		
Ipecac and Actidose	PO (liquid)	Per label instructions	PRN-Accidental poisoning		
Ivy Block and Tecnu	Topical (cream)	Per label instructions	Q 4 hrs PRN Contact with poison ivy		
Muscle rub	Topical (cream)	Per label instructions	PRN Minor muscle strains or pains		
Non-Toxic Anti Lice preparation	Topical (liquid)	Per label instructions	PRN – Head lice		
Orasol, Ambesal, and Abreva	Topical (liquid or cream)	Per label instructions	Q 6 hrs PRN – Oral herpes, cold sores, toothache		
Pepto-Bismol	PO (liquid or chewable tabs)	Per label instruction by age/weight	Q 30 min to 1 hr PRN for diarrhea (no >8 doses/ 24 hr)		
Pseudoephadrine	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN – Nasal/sinus congestion, hay fever, allergies		
Robitusin/ Robitusin DM	PO (liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN Coughs		
Tylenol	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN – Pain , fever, cold symptoms, toothache, muscle aches		
Visine	Optical (liquid)	Per label instructions	PRN – Eye strain, eye irritation		
Polysporin	Topical ointment	Per label instructions	PRN – burns,scrapes		

LICENSED MEDICAL PERSONNEL SIGNATURE: ____________________________________ TITLE: __________________

PARENT SIGNATURE (optional: ____