

D.

Allergies

The following information must be filled in by the parent/guardian. The intent of this information is to provide camp health care personnel the background to provide 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 needs.

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

Medication allergies (list)

Food allergies (list)

Other allergies (list)

E.

General Questions

General Questions: (Explain "yes" answers below.)

Yes/No

Yes/No

Has/does the participant:

- | | | | |
|--|-------|--|-------|
| 1. Have any recent injury, illness or infectious disease? .. | Y / N | 16. Ever been diagnosed with a heart murmur? .. | Y / N |
| 2. Have a chronic or recurring illness/condition? | Y / N | 17. Ever had back problems? | Y / N |
| 3. Ever been hospitalized? | Y / N | 18. Ever had problems with joints? | Y / N |
| 4. Ever had surgery? | Y / N | 19. Wear a removable orthodontic appliance? ... | Y / N |
| 5. Have frequent headaches? | Y / N | 20. Have any skin problems? | Y / N |
| 6. Ever have a head injury? | Y / N | 21. Have diabetes? | Y / N |
| 7. Ever been knocked unconscious? | Y / N | 22. Have asthma? | Y / N |
| 8. Wear glasses, contacts, or protective eye wear? | Y / N | 23. Had mononucleosis in the past 12 months? .. | Y / N |
| 9. Ever had frequent ear infections? | Y / N | 24. Had problems with diarrhea/constipation? ... | Y / N |
| 10. Ever passed out during or after exercise? | Y / N | 25. Have problems with sleepwalking? | Y / N |
| 11. Ever been dizzy during or after exercise? | Y / N | 26. If female, abnormal menstrual history? | Y / N |
| 12. Ever had seizures? | Y / N | 27. Have a history of bed-wetting? | Y / N |
| 13. Ever had chest pain during or after exercise? | Y / N | 28. Ever had an eating disorder? | Y / N |
| 14. Ever had high blood pressure? | Y / N | 29. Ever had emotional difficulties for which | |
| 15. Ever had bleeding/clotting disorder? | Y / N | professional help was sought? | Y / N |

Please explain "yes" answer(s), noting the number of the question(s).

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

F. Restrictions

RESTRICTIONS
The following restrictions apply to this individual:

Dietary, circle all that apply

Does not eat red meat Does not eat pork Does not eat eggs
 Does not eat poultry Does not eat seafood Does not eat dairy products

Other (describe) _____

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

G. Immunization History

	Which of the following has the participant had?	Please give all dates of immunizations:					
		Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Measles	Tetanus	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German measles	DTP	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Chicken pox	TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Polio	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	MMR	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Measles	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Mumps	_____	_____	_____	_____	_____	_____
	or Rubella	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> TB Mantoux test	Haemophilus Infuenza B	_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B	_____	_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (Chicken pox)	_____	_____	_____	_____	_____	_____

H. Medical Examination

To be filled out by a licensed Physician, Physician Assistant, or Registered Nurse. **This examination should be performed within 24 months of arrival at camp.** Examination for some other purpose within this period is acceptable. (Attach form.) Examination is for determining fitness to engage in strenuous activities.

Please mark "S" for Satisfactory and explain any unsatisfactory items. (Attach page)

Height _____ Weight _____ B.P. _____
 Eyes _____ Throat _____ Abdomen _____ General Appraisal: _____
 Glasses/Contacts _____ Heart _____ Hernia _____ Ears _____ Skin _____
 Extremities _____ Nose _____ Lungs _____ Posture (Spine) _____

Allergy (Please specify) _____
 Recommendations and restrictions while in camp: Special Diet (See Section F) _____
 Current Medications _____
 Swimming _____ Strenuous activity _____
 Other _____

(For Girls and Women) Has this person menstruated? _____ If not, has she been told about it? _____
 If so, is her menstrual history normal? _____ Special considerations: _____

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

 Physician, Physician Assistant, or Registered Nurse

 Date

Telephone (____) _____ Address _____

I. PICK-UP AUTHORIZATION

_____ is authorized to pick up
(Name of person authorized to pick up camper)

_____ at the conclusion of camp.
(Camper Name)

_____ (Date)
(Signature of Parent/Guardian)

J. MEDICATION AUTHORIZATION

Any prescription or over-the-counter medications brought to camp need to be in original containers and listed on this form.

Camper Name: _____ Birth Date: _____ Camp #: _____

Name of Medication _____ Date Prescribed: _____
Dosage: _____ Frequency: _____
Method of Administration: _____ Duration: _____
Possible Side Effects: _____
Special Instructions: _____
Why has this medication been prescribed? _____
Contact the Physician When: _____

Name of Medication _____ Date Prescribed: _____
Dosage: _____ Frequency: _____
Method of Administration: _____ Duration: _____
Possible Side Effects: _____
Special Instructions: _____
Why has this medication been prescribed? _____
Contact the Physician When: _____

Name of Medication _____ Date Prescribed: _____
Dosage: _____ Frequency: _____
Method of Administration: _____ Duration: _____
Possible Side Effects: _____
Special Instructions: _____
Why has this medication been prescribed? _____
Contact the Physician When: _____

Please label ALL medications clearly including the following information and keep in original containers:

- 1) Camper or staff member name; 2) Name of medication; 3) Dosage; 4) Frequency of administration; 5) Method of administration;
and

If the medication has been prescribed by a physician, the label *must* also include:

- 6) Name of prescribing physician; 7) Prescription number; 8) Date prescribed; 9) Possible adverse reactions; 10) Specific conditions when contact should be made with physician; 11) Other special instructions:

TO BE FILLED IN BY CAMP HEALTH SUPERVISOR

List routine treatment required during camp period, for example, further examination, special food, injections, or prescriptions:

Record of illness or accidents:		
DATE	COMMENT	TREATMENT

Conditions arising in camp which should be called to the attention of the parents or guardians:

Record medical reimbursement claims: _____

Signature of Camp Health Supervisor _____ Date _____

(For insurance purposes, this record should be kept on file in the camp site office.)