

Camp High Rocks

Camper Medical Information (Rev. 2/2010)

Year: _____ Session: _____

Name: _____
Last First Middle Initial

Age at camp: _____ Birth Date: _____
Month/Day/Year

Home Address: _____
Street Address City State Zip

Custodial Parent or Legal Guardian: _____ Relationship: _____

Home Address: _____
(if different than above) Street Address City State Zip

Home Phone: _____ Work Phone: _____ Cell: _____

Non-Custodial Parent or Guardian: _____

Home Phone: _____ Work Phone: _____ Cell: _____

HEALTH AND ACCIDENT INFORMATION:

Person to contact in case of an emergency should parents be unavailable: _____

Home/Cell Phone: _____ Work Phone: _____ Relationship: _____

This section must be completed for camp attendance

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

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

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, surgery and anesthesia for the person named above. This completed form may be photocopied for trips out of camp.

Signature of Parent or Guardian: _____ Date _____

Printed Name: _____

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

Signature of Minor: _____ Date _____

Printed Name: _____

HEALTH HISTORY:

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

Please give all dates of immunization for:

Vaccine	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/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

Date of last test _____

Result: Positive Negative

GENERAL QUESTIONS: (*Explain “yes” answers below*)

Does/Has the participant have/had:

- | | | | | | |
|--|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| 1. Recent injury, illness or infectious disease? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 16. Ever had problems with joints (e.g., knees, ankles)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Chronic or recurring illness/condition?..... | <input type="checkbox"/> | <input type="checkbox"/> | 17. Back problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Hospitalization?..... | <input type="checkbox"/> | <input type="checkbox"/> | 18. Orthodontic appliance being brought to camp? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Skin problems (e.g., itching, rash, acne)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Frequent headaches?..... | <input type="checkbox"/> | <input type="checkbox"/> | 20. Allergy to latex? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Head injury? | <input type="checkbox"/> | <input type="checkbox"/> | 20. ADD or ADHD?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eyewear?..... | <input type="checkbox"/> | <input type="checkbox"/> | 22. Asthma?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Mononucleosis in the past 12 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Problems with diarrhea / constipation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Dizzy during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> | 25. Problems with sleepwalking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Seizures?..... | <input type="checkbox"/> | <input type="checkbox"/> | 26. History of bed-wetting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 27. An eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. High blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Emotional difficulties for which professional help was sought? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Diagnosed with a heart murmur?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Complete this section if you answered “yes” to the following:

Asthma:

Uses inhaler: _____ Uses neb unit: _____ Frequency: _____
Normal peak flow: _____

Diabetes:

Uses insulin: _____ Counts carbs: _____
Normal blood sugar range: _____ Glucometer: _____

Please explain other “yes” answers and note the number of the question.

ALLERGIES: *List all known.*

Describe reaction and management of the reaction.

Medication Allergies (please list)

Food Allergies (please list)

Other Allergies (please list) – include insect stings, hay fever, animal dander, latex, etc.

CURRENT MEDICATIONS:

List all medications, including over the counter or non-prescription drugs taken on a regular basis **and including those medications, which are administered ONLY during the school year and will not be administered during camp (please explain in space provided below)**. For camp medications, please bring enough medication (in its original container) to last the entire time at camp. For a prescription medication, the original container must list the prescribing physician, name of medication, and dosage information.

Medication #1: _____ Dosage: _____

Specific times taken each day: _____

Reason for taking: _____

Medication #2: _____ Dosage: _____

Specific times taken each day: _____

Reason for taking: _____

Medication #3: _____ Dosage: _____

Specific times taken each day: _____

Reason for taking: _____

Use this space to provide additional information regarding Medications.

RESTRICTIONS:

Dietary:

- 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 **activity** restrictions: _____

Name of family physician: _____ Phone: _____

Address: _____

Name of family dentist/orthodontist: _____ Phone: _____

Address: _____

CAMPER NAME: _____

HEALTH CARE RECOMMENDATION BY LICENSED PHYSICIAN:

A physical examination must be current within two years of participant's attendance at camp. If a physical has been completed within that time, please arrange for the physician to complete the following information and sign.

Height: _____ Weight: _____ BP: _____

Recommendations / Restrictions:

Medicines / treatments to be administered at camp (be specific):

Allergies (food, drugs, insects, etc.) or medically prescribed dietary restrictions:

I have examined the above participant and find that he is able to participate in an active camp program, with the following exceptions:

Signature of Licensed Physician _____

Printed _____ Title _____ Date _____

Office Phone: _____ Evening Phone: _____

For camp use only

Screening Record Campers should be screened within the first 24 hours of arrival.

Date screened: _____ Time: _____ am / pm

Updates / additions to health history noted: No Yes See notes below

Signs or symptoms of illness or injury? No Yes See notes below

Medication given to health-care staff? No Yes See notes below

Meds received: _____

Current health needs identified: _____

Observational notes: _____

Screened by _____