

GENERAL QUESTIONS: (Explain "yes" answers below)

Does/Has the participant have/had:

- | | | | | | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Recent injury, illness or infectious disease?..... | Yes | No | 16. Ever had problems with joints (e.g., knees, ankles)?..... | Yes | No |
| 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"/> | 21. ADD or ADHD?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Asthma?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | 24. 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"/> | 25. Problems with diarrhea / constipation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Problems with sleepwalking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Seizures?..... | <input type="checkbox"/> | <input type="checkbox"/> | 27. History of bed-wetting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 28. An eating disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. High blood pressure?..... | <input type="checkbox"/> | <input type="checkbox"/> | 29. 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: _____ Co unts 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 _____