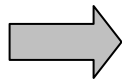




Confidential Health History



This form must be mailed in, or brought to camp prior to start of session! No forms accepted by fax.

Camper Name:

| | | | | | |
|-------------|--------------|---------------|-------------------|------------|------------|
| | | | | | |
| Last | First | Middle | Birth date | Sex | Age |

Parent or Guardian:

| | |
|--------------|--------------|
| Home Address | Work Address |
| City/State | City/State |
| Zip Code | Zip Code |
| Phone () | Phone () |

If not available in case of emergency, notify:

| | |
|--------------|--------------|
| Home Address | Work Address |
| City/State | City/State |
| Zip Code | Zip Code |
| Phone () | Phone () |

Doctor Information:

Medical Insurance Information:

| | | |
|-----------------|---------------------|------------------------|
| Physician Name: | Phone Number () | Carrier Name |
| Dentist Name: | Phone Number () | Policy or Group Number |

Health History (Check all that apply):

Diseases:

Allergies:

| | | |
|--------------------------------------|--------------------------------|--------------------------------|
| Frequent Ear Infections | Chicken Pox | Hay Fever |
| Heart Defect/Disease | Measles | Ivy Poisoning, etc. |
| Convulsions/Epilepsy | German Measles | Insect Stings |
| Diabetes | Mumps | Penicillin |
| Bleeding/Clotting Disorders | Mononucleosis | Other Drugs |
| Hypertension | Other (<i>specify below</i>) | Asthma |
| Psychiatric Treatment | | Other (<i>specify below</i>) |
| Operations or Serious Injuries | | |
| Disability/Chronic/Recurring Illness | | |
| Bed Wetting | | |

If female, has applicant menstruated? _____

If so, is her menstrual history normal? _____

If not, has she been told about it? _____

Special considerations? _____

Immunization History:

| Vaccines | Year of Basic Immunization | Year of Last Booster |
|--|----------------------------|----------------------|
| DPT (Diphtheria, Pertussis, Tetanus) | | |
| TD (Tetanus, Diphtheria) | | |
| Tetanus | | |
| Oral Polio (Sabin) TOPV | | |
| Injectable Polio (Salk) | | |
| Measles (Hard measles, Red measles, Rubeola) | | |
| Mumps | | |
| Rubella (German measles, 3-day measles) | | |
| Tuberculin test | | |
| Haemophilus influenza b (HIB) | | |

THIS BOX MUST BE COMPLETED FOR ATTENDANCE

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director, to order X-rays, routine tests, treatment, and necessary 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 director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp.

Parent/Guardian/Adult Camper/Staffer Signature: _____ **Date:** _____

Camper Physical Examination Form

| | | | |
|-------------|--------|--------|----------------|
| | | | |
| Camper Name | Height | Weight | Blood Pressure |

Health care recommendations by a licensed physician

Date examined: _____

I have examined the above camp applicant within the past two years. In my opinion, the above's condition *does* _____ *does not* _____ preclude his/her participation in an active camp program.

The applicant is under the care of a physician for the following condition(s): _____

Current treatment (*include current medications*): _____

Explanation of any reported loss of consciousness, convulsion, or concussion: _____

Does applicant have epilepsy? _____ Does applicant have diabetes? _____

Recommendations and Restrictions while at Camp

Any treatment to be continued at camp: _____

Any medication to be administered at camp (*specific dosages*): _____

Any medically prescribed meal plan or dietary restrictions: _____

Any activities encouraged or limited at camp: _____

Any allergies (*food, drugs, plants, insects, etc*): _____

Additional health information: _____

| |
|--|
| Licensed Physician's Signature _____ |
| Address _____ Phone (____) _____ |
| Date of Form Completion _____ *By _____ <i>Initial if completed by nurse or physician's assistant</i> |

