HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

I have examined the above camp participant on this date_____(Must be within 12 months prior to camp)

BP_____ Weight_____ Height_____

In my opinion, the above applicant ◯ is ◯ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions_____

_____

Current treatment at the time of this report includes_____

_____

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._____

MEDICATIONS BEING TAKEN

Please check one:

◯ **This person takes NO medications on a routine basis.**

◯ **This person takes medications as follows.**

Please list ALL medications (including over -the-counter or nonprescription drugs) taken routinely.

*Med #1*_____*Dosage*_____*Specific times taken each day*_____

Reason for taking _____

*Med #2*_____*Dosage*_____*Specific times taken each day*_____

Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does not take during the summer:

_____

_____

Signature of Licensed Medical Personnel X_____

Printed_____ Title_____

Address_____

Phone (_____)_____Date_____

Licensed Medical Personnel
is defined as:

Medical Doctor, Doctor Of Osteopathy, Licensed Nurse Practitioner, Or Licensed Physician's Assistant Only

Licensed Medical Personnel Official Stamp

Housing

Name

STAR LAKE CAMP

Health History and Examination Form

ACCREDITED

THE SALVATION ARMY

The information on this form is gathered to assist us in identifying appropriate care. Be sure all necessary signatures and attachments are included. Please keep a copy for your own records.

PERSONAL INFORMATION

Name_____Birthdate_____Age at Camp_____

Home Address_____City _____Zip _____

Gender: Male ◯ Female ◯

Parent/Guardian Name_____ Phone (_____)_____

Business Address_____ Phone (_____)_____

Emergency Contact #1_____ Phone (_____)_____
(Other Than Parent/Guardian)

Relationship _____ Phone (_____)_____

Emergency Contact #2_____ Phone (_____)_____
(Other Than Parent/Guardian)

Relationship _____ Phone (_____)_____

INSURANCE INFORMATION

Please attach copy of insurance card front and back

Is the participant covered by family medical/hospital insurance? Yes ◯ No ◯

If yes, indicate carrier or plan name_____

Group#_____

Carrier Address _____

Name of Insured_____ Relationship _____

ID number_____

IMPORTANT - *This box must be completed for eligibility requirements*

Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by the Camp Director to order X-rays, routine tests, treatment, to release any records necessary for insurance purpose; and to provide or arrange for necessary related transportation. In in an emergency, I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Your Signature (or Parent/Guardian if under 18) **X**_____Date_____

GENERAL HEALTH QUESTIONS

Please complete the following information (must be completed by parent/guardian if under 18). 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 of information on this form should be provided to camp health personnel upon participant's arrival at camp. Provide complete information so that the camp can be aware of your needs.

Has/does the participant:

(explain "yes" answers below)	YES	NO		YES	NO
1. Had any recent injury, illness, or infectious disease?	❑	❑	16. Ever had back problems?	❑	❑
2. Have a chronic or reocurring illness/condidion?	❑	❑	17. Ever had problems with joints(e.g. knees/ankles)?	❑	❑
3. Ever been hospitalized?	❑	❑	18. Have an orthodontic appliance being brought to camp?	❑	❑
4. Ever had surgery?	❑	❑	19. Have any skin problems (e.g. itching, rash, acne)?	❑	❑
5 Have frequent headaches?	❑	❑	20. Have diabetes?	❑	❑
6. Ever had a head injury?	❑	❑	21. Have asthma?	❑	❑
7. Ever been shocked unconscious?	❑	❑	22. Had mononucleosis in the past 12 months?	❑	❑
8. Wear glasses, contacts, or protective eye-wear?	❑	❑	23. Had problems with diarrhea/constipation?	❑	❑
9. Ever had frequent ear infections?	❑	❑	24. Have problems with sleepwalking?	❑	❑
10. Ever passed out during or after exercise?	❑	❑	25. If female, have an abnormal menstrual history?	❑	❑
11. Ever been dizzy during or after exercise?	❑	❑	26. Have a history of bed-wetting?	❑	❑
12. Ever had seizures?	❑	❑	27. Ever had an eating disorder?	❑	❑
13. Ever had chest pain during or after exercise?	❑	❑	28. Ever had emotional difficulties for which professional help was sought?	❑	❑
14. Ever had high blood pressure?	❑	❑			
15. Ever been diagnosed with a heart murmer?	❑	❑			

Please explain any "yes" answers, noting the number of the questions _____

_____

ALLERGIES *(List all known) - Describe reaction and management of the reaction.*

Medication Allergies

_____

_____

_____

Food Allergies

_____

_____

_____

NAME OF FAMILY DENTIST/ORTHODONTIST _____

Address _____ City _____ Zip _____

Phone (_____) _____

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

Your Signature (or Parent/Guardian if under 18) X _____

Witness _____ Date _____

HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

Licensed Medical Personnel Is Defined As:

Medical Doctor, Doctor Of Osteopathy, Licensed Nurse Practitioner, Or Licensed Physician's Assistant Only

DISEASES AND IMMUNIZATIONS Starred (*) immunizations must be current. Copies of a physician statement, a government immunization record, or a school immunization record is also acceptable. The date of last Tetanus immunization is required.

Please attach a copy of your current diseases and immunization record

Which of the following has the participant had?

- ❑ Measles
- ❑ Chicken Pox
- ❑ German Measles
- ❑ Mumps
- ❑ Hepatitis
- ❑ TB Mantoux Test

Date of last test_____

Result:

❑ Positive ❑ Negative

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)	____	____				
BCG	____					

RESTRICTIONS

Dietary _____

_____

Physical Activities(e.g. what cannot be done, what adaptations or limitations are necessary) _____

_____

_____

Bring enough medication to last the entire time at camp.

Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

All Medicines listed by the doctor MUST BE BROUGHT TO CAMP unless so indicated by the doctor.

For Camp Use Only

Screening Record Screened by _____

Date Screened _____ Time _____

Medications Received _____

Current health needs identified or other observational notes _____