

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



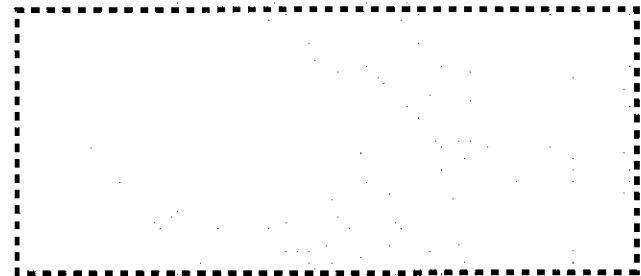
Printed _____ Title _____

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



Health History and Examination Form



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 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 _____

Housing

Name

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?	<input type="checkbox"/>	<input type="checkbox"/>	16.	Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17.	Ever had problems with joints (e.g. knees/ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18.	Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19.	Have any skin problems (e.g. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20.	Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21.	Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Ever been shocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22.	Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Wear glasses, contacts, or protective eye-wear?	<input type="checkbox"/>	<input type="checkbox"/>	23.	Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24.	Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25.	If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26.	Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27.	Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28.	Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>				
15.	Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>				

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 _____

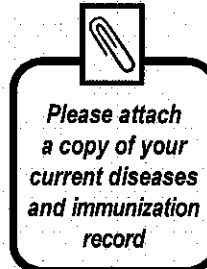
HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL



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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 _____