Year

Cabin or Group

Name

Health History and Examination Form for Children, Youth and Adults

Mail this form to the address below by (date)

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians of minors or by adults themselves. Update required annually. Health exam (back page) must be completed by approved licensed medical personnel at least every two years.

Name _____
Last First Middle Birth date Age at camp

Home address _____
Street Address City State Zip

Social security number of participant _____ Sex: ☐ Male ☐ Female

Custodial Parent/guardian _____ Phone _____

Home address _____
Street Address City State Zip

Business address _____
(if different from above) Street Address City State Zip Phone

Second parent or guardian or emergency contact _____

Home address _____
Street Address City State Zip

Business address _____
Street Address City State Zip Phone

If not available in an emergency, notify _____

Relationship _____ Phone _____

Address _____
Street Address City State Zip

Insurance Information

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

If so, indicate carrier or plan name _____ Group # _____

Important—The following boxes MUST be complete for 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 me/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; (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, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____

Printed Name _____ Date _____

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

Signature of minor or adult camper/staffer _____

Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. 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 to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known Describe reaction and management of the reaction.

Medication allergies (list)

_____

_____

_____

Food allergies (list)

_____

_____

_____

Other allergies (list)—include insect stings, hay fever, asthma, animal dander, etc.

_____

_____

_____

MEDICATIONS BEING TAKEN

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

☐ This person takes NO medications on a routine basis.

☐ This person takes medications as follows

Med #1_____Dosage _____Specific times taken each day _____

Reason for taking _____

Med #2_____Dosage_____Specific times taken each day _____

Reason for taking _____

Med #3_____Dosage_____Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications. Also identify any medications taken during the school hear that participant does/may not take during the summer: _____

_____

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

☐ Does not eat red meat ☐ Does not eat poultry ☐ Does not eat pork

☐ Does not eat seafood ☐ Does not eat eggs ☐ Does not eat dairy products

☐ Other (describe) _____

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary)

_____

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (ACA-accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

Blood Pressure _____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:

_____

_____

_____

_____

Recommendations and Restrictions at Camp

Treatment to be continued at camp_____

_____

Medications to be administered at camp (name, dosage, frequency) _____

_____

Any medically-prescribed meal plan or dietary restrictions _____

_____

Known allergies_____

_____

Description of any limitation or restriction on camp activities _____

_____

Additional information for health care staff at the camp _____

_____

Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

For camp use only

Screening Record

Date screened _____ Time _____am pm

Meds received _____

_____

Updates/additions to health history noted ☐ Yes ☐ No ☐ None required

Current health needs identified _____

_____

Observational notes _____

_____

Screened by_____