

Camp Croix Health History and Examination Form

Dates of Camp Attendance:

Camper, bring this form to Camp and give to the nurse at registration. Staff, bring this form when reporting for duty.

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 must be filled out by parents/guardians of minors or by adults themselves. Updated form required annually. Health exam must be completed by approved licensed medical personnel at least every two years. It is your responsibility as parent/guardian to inform us of any changes in your child's health condition upon arrival of camp.

GENERAL INFORMATION

Participant's Name			Birth date	Age at Camp
<i>Last</i>	<i>First</i>	<i>Middle</i>		
Home address				
<i>Street Address</i>		<i>City</i>	<i>State</i>	<i>Zip</i>
E-mail address			(circle one) Male Female	
Father's Information – First and Last Name			Home Phone:	
<i>Business Name</i>			Cell Phone:	
			Work #:	
Home address				
<i>(if different from above) Street address City State Zip</i>				
Mother's Information – First and Last Name			Home Phone:	
<i>Street address</i>			Cell Phone:	
<i>Business Name</i>			Work #:	
IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY:				
Name			Relationship	
Address			Home Phone:	
<i>Street address</i>			Cell Phone:	
<i>City</i>			Work #:	
<i>State</i>				
<i>Zip</i>				

INSURANCE INFORMATION

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

If so, print insurance carrier or plan name:

Address:

Group or policy #:

Should there be any medical expenses resulting from an accident at camp, Camp Croix's Insurance policy requires us to file with the camper's individual insurance first; any part of the bill not covered by the camper's insurance can then be filed with our insurance company. Bills from an illness requiring medical attention are the sole responsibility of the camper.

Parent/ Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. (The camp medical staff will always attempt to contact you in case a trip to the hospital is necessary.)

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 complete form may be photocopied for trips out of camp.

Signature of parent/guardian _____

Print Name _____ Date _____

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

Signature of Camper _____ Date _____

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

Medication allergies (list) Penicillin, Tylenol, aspirin, etc.	Describe reaction and management of the reaction
Food allergies (list)	
Other allergies (list) Include insect stings, hay fever, poison ivy, asthma, animal dander, ect.	

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription 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 follow:

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

Immunization History Please record the month and year of the basic and most recent booster doses:

DPT 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Sabin Polio 1. _____ 2. _____ 3. _____ 4. _____

Measles 1. _____ 2. _____

Mumps 1. _____

Rubella 1. _____

MMR 1. _____ 2. _____

HIB 1. _____

Haemophilus Influenza Type B _____ Hepatitis B _____ Varicella (Chicken Pox) _____

Tuberculin Test: (within last 12 months) Date _____ Results _____

For Female Campers

Has this person menstruated? Y/N If no, has she been informed of it? Y/N

If yes, is her menstrual history normal? Y/N

Any medically prescribed meal plan or dietary restrictions:

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

GENERAL QUESTIONS (Explain "yes" answers below.) Has/does the participant

Yes No

Yes No

- 1. Had any recent injury, illness or infections diseases?
- 2. Have a chronic or recurring illness/condition?
- 3. Ever been hospitalized or had a surgery?
- 4. Ever had chicken pox, measles, German measles, whooping cough or mumps? List below
- 5. Have frequent headaches?
- 6. Ever had a head injury or been knocked unconscious?
- 7. Ever had an eating disorder or stomach problems?
- 8. Wear glasses, contacts or protective eye wear?
- 9. Ever had frequent ear infections?
- 10. Have asthma?
- 11. Ever been dizzy or passed out during or after exercise?
- 12. Ever had seizures? epilepsy?
- 13. Ever had chest pain during or after exercise?
- 14. Ever had high blood pressure?

- 13. Ever been diagnosed with a heart murmur, defect or disease?
- 16. Ever had back problems?
- 17. Ever had problems with joints (e.g. knees, ankles)?
- 18. Have an orthodontic appliance being brought to camp?
- 19. Have any skin problems (e.g., itching, rash acne)?
- 20. Have diabetes?
- 21. Have asthma?
- 22. Had mononucleosis in the past 12 months?
- 23. Had problems with diarrhea/constipation?
- 24. Have problems with sleepwalking?
- 25. Had any bleeding or clotting disorders?
- 26. Have a history of bed-wetting?
- 27. Ever had behavioral issues or mental illness?
- 28. Ever had emotional difficulties or behavioral issues for which professional help was sought or recommended?

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

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.

Name of camper's/staff's physician _____

Phone _____

Address _____

Name of camper's/staff's dentist/orthodontist _____

Phone _____

Address _____

The applicant is under the care of a physician for the following conditions:

<p>Signature Of Licensed Medical Personnel: _____</p> <p>Printed _____ Title _____</p> <p>Address _____</p> <p>Phone _____ Date _____</p>
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<p>Screening Record (For Camp Croix Personnel Only)</p> <p><i>Date screened</i> _____</p> <p><i>Time</i> _____</p> <p><i>Meds received</i> _____</p> <p><i>Observation notes</i> _____</p>
