HEALTH FORM **20__ Update**

CAMP DATES *(List dates for each week)* ______________________________

This form must be completely filled out and returned to Camp ______________________________, at least **30 days prior** to the start of your camp session. Please make all non-emergency calls to camp only between regular office hours, 8:00 a.m. – 5:00 p.m. *(Eastern Time),* Monday – Friday. Thank-you very much!

Name: ______________________________ ***Sex:*** M F ***Age:*** __________

Last First Middle Initial

Birth Date: ____/____/____

Mother/Guardian #1: ______________________________ ***Home Phone:*** ( )________

Home Address: ______________________________

Street & Number City State Zip Code

Work Phone: ( )________ ***Cell Phone:*** ( )________

Father/Guardian #2: ______________________________ ***Home Phone:*** ( )________

Home Address: ______________________________

Street & Number City State Zip Code

Work Phone: ( )________ ***Cell Phone:*** ( )________

If neither of the above is available in an emergency, please notify:

Alternate Contact #1: ______________________________ ***Home Phone:*** ( )________

Name

Work Phone: ( )________ ***Cell Phone:*** ( )________

Alternate Contact #2: ______________________________ ***Home Phone:*** ( )________

Name

Work Phone: ( )________ ***Cell Phone:*** ( )________

Name of Dentist/Orthodontist: ______________________________ ***Phone:*** ( )________

Name of Family Physician: ______________________________ ***Phone:*** ( )________

Do you have family medical/hospital insurance? ________ ***If yes, Policy Holder's Name:*** ______________________________

Employer through which insurance is obtained: ______________________________

Carrier: ______________________________ ***Policy or Group #:*** ______________________________

Do you have family prescription drug insurance? ***If yes, Policy Holder's Name:*** ______________________________

Carrier: ______________________________ ***Policy or Group #:*** ______________________________

IMPORTANT - MUST BE COMPLETED FOR ATTENDANCE

Parent's Authorization: This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities, except as noted by the examining physician and/or I. I understand there is some inherent risk in activities at camp and accidents sometimes occur. I understand that the camp fee does not include accident insurance. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I hereby give permission to the physician selected by the camp director to order x-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my child as named above. I agree that after a place is reserved he or she will remain until the end of the period unless necessary to withdraw due to illness as defined by the camp physician. I understand that no refunds are given if a child leaves early because of homesickness or for disruptive behavior as decided by the camp director. I give permission for ___________ to use photos or videos of my child in promotional literature.

I understand that if my child has special health issues I must call the camp at least 90 days in advance of the camper's stay to determine if the camp can provide the level of health care needed by my child. I understand that ________________________ is not a healthcare facility and may not be able to reasonably care for my child's special needs. Health conditions requiring advance clearance include, but may not be limited to:

Insulin Dependent Diabetes	Cardiac Situations	Asthmatics
Seizure Disorders	Autism	Serious Food Allergies

Parent/Guardian Signature: ______________________________ ***Date:*** ______________________________

Witness Signature: ______________________________

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IMPORTANT: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance, or if camper has been seen by a physician for any reason during this period.

Continued on backside...

Last Name: ______________________________

First Name: ______________________________

CAMPER MEDICAL HISTORY – To be completed by Parent.

Health History: *(check - giving approximate dates).*

Health History	*Allergies*	*Diseases*
______ Frequent Ear infections	______ Hay Fever	______ Rheumatic Fever
______ Heart Defect/Disease	______ Poison Ivy, etc.	______ Chicken Pox
______ Convulsions	______ Insect Stings	______ Measles
______ Diabetes (onset)	______ Penicillin	______ German Measles
______ Bleeding/Clotting Disorders	______ Other Drugs	______ Mumps
______ Epilepsy (onset)	______ Peanuts	______ Asthma
______ Tonsillitis	______ Other Foods	______ Strep Throat
		______ Mononucleosis

Other diseases or details of the above: ______________________________

Operations or serious injuries (dates): ______________________________

Chronic or recurring illness or Special Needs: ______________________________

(For Girls) Has this camper menstruated? ______ ***If no, has she been told about it?*** ______ ***If yes, is her menstrual history normal?*** ______

Special considerations or suggestions: ______________________________

Are there any over-the-counter, non-prescription medications or ointments that SHOULD NOT be given to your child? (i.e. Tylenol, bug repellent, Sudafed, etc.)

____

MEDICAL EXAMINATION – TO BE FILLED OUT BY LICENSED PHYSICIAN

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities. Laboratory test done at discretion of physician.

CODE: V = Satisfactory; X = Not satisfactory (explain); O = Not examined

Height: ______ ***Weight:*** ______ ***BP:*** ______ ***Resting Pulse:*** ______

______ ***Eyes***	______ ***Lungs***	***Allergies (please specify):*** ______
______ ***Glasses***	***Abdomen***	______
______ ***Ears***	***Hernia***	______
______ ***Nose***	______ ***Extremities***	***General Appraisal:*** ______
______ ***Throat***	______ ***Posture (Spine)***	______
______ ***Heart***	______ ***Skin***	______
______ ***Genitalia***		

Immunizations are up-to-date: *Yes* *No* ***Reason:*** ______________________________

REQUIRED
Date of last Tetanus Vaccine:
______ (Month/Year)

Recommendations and restrictions while at camp:

Swimming/Diving: ______ ***Strenuous Activity:*** ______

Other: ______ ***Special Diet:*** ______

Current medications *(list name, dosage and time schedule)* ***All medications must be in a*** **correctly labeled original container** ***and given to the nurse at check-in time. NO MEDICATIONS (PRESCRIPTION OR OVER-THE-COUNTER) WILL BE ALLOWED IN THE CABIN UNLESS AUTHORIZED BY THE NURSE.***

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I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

Doctor signs here: ______________________ ***M.D.*** ***Date:*** ______

Address: ______________________ ***Phone:*** ( ) ______

______________________ ***FAX:*** ( ) ______

Last Name: ______

First Name: ______