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: _____

Continued on backside...

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).*

_____ 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

Allergies ***Diseases***

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.***

_____

_____

_____

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: _____