

Health History and Examination Form for Children and Adults Attending Camp Floyd Rogers

Health history (first three pages) must be filled out by parents/guardians of minors or by adults themselves. Health exam (page 4) must be completed by approved licensed medical personnel.

Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address _____
Street Address City State Zip

Social security number of participant _____ Gender: Male Female

Custodial parent/guardian _____ Phone _____

Home address _____
Street Address City State Zip

Business address _____ Phone _____
Street Address City State Zip

Second parent or guardian or emergency contact, _____

Address _____ Phone _____
Street Address City State Zip

Business address _____ Phone _____
Street Address City State Zip

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 # _____

Photocopy of front and back of health insurance card must be attached to this form.

*****Important — These 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: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (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 _____ Date _____

If for religious reasons you cannot sign this, contact the camp for a legal waiver, which must be signed for attendance.

Health History Information

<p>Which of the following has the participant had?</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Chicken Pox</p> <p><input type="checkbox"/> German Measles</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Hepatitis A</p> <p><input type="checkbox"/> Hepatitis B</p> <p><input type="checkbox"/> Hepatitis C</p> <p>TB Mantoux Test Date of last test _____</p> <p>Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative</p>	<p>Please give all dates of immunization:</p> <table border="0"> <tr> <td>Vaccine:</td> <td>Mo/Yr</td> <td>Mo/Yr</td> <td>Mo/Yr</td> <td>Mo/Yr</td> <td>Mo/Yr</td> <td>Mo/Yr</td> </tr> <tr> <td>DTP</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>TD (Tetanus/diphtheria)</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Tetanus</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Polio</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>MMR</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>or Measles</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>or Mumps</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>or Rubella</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Haemophilus influenza B</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Varicella (chicken pox)</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>BCG</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	Vaccine:	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	_____	_____	_____	_____	_____	_____	Varicella (chicken pox)	_____	_____	_____	_____	_____	_____	BCG	_____	_____	_____	_____	_____	_____
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Does the participant currently have (or had) any of the following? Check "yes" or "no" to each question. Please explain any "yes" answers (noting of the number of the question) in the space below or on an additional sheet of paper, if necessary.

	YES	NO		YES	NO
1. Had recent injury, illness or infectious disease?	___	___	11. Have diabetes or hypoglycemia?	___	___
2. Have a chronic or recurring illness or condition?	___	___	12. Have asthma?	___	___
3. Been hospitalized/had surgery within the past 2 years?	___	___	13. Had mononucleosis in the past 12 months?	___	___
4. Have frequent headaches?	___	___	14. Had seizures?	___	___
5. Had a head injury and/or been knocked unconscious?	___	___	15. Had frequent ear infections?	___	___
6. Has passed out, been dizzy, and/or had chest pain during or after exercise?	___	___	16. Wear glasses, contacts or protective eye wear?	___	___
7. Had heart-related problem (high/low blood pressure, shortness of breath, murmurs, etc.)?	___	___	17. Have an orthodontic appliance?	___	___
8. Had muscular/skeletal problems (arthritis, hernia, recent fractures, back/joint problems)?	___	___	18. Have problems with sleepwalking?	___	___
9. Had stomach/Intestinal problems (ulcers, jaundice, indigestion, diarrhea/constipation)?	___	___	19. If female, have an abnormal menstrual history?	___	___
10. Have any skin problems (itching, rash, acne)?	___	___	20. Have a history of bed-wetting?	___	___
			21. Had an eating disorder?	___	___
			22. Had emotional difficulties for which professional help was sought?	___	___

If yes, please give details (i.e. reactions, special instructions, special equipment, procedures: attach additional pages if necessary)

Diet, Nutrition

1. This camper eats a regular diet 2. This camper eats a regular vegetarian diet 3. This camper has special food needs (Please describe) _____

Activity Restrictions

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

Allergies: No known allergies This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other (Please indicate below what the camper is allergic to and the reaction seen and management of the reaction) _____

Mental, Emotional, and Social Health : Has the camper : “Yes: or “No” for each statement

Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD) _____

Ever been treated for emotional or behavioral difficulties or an eating disorder? _____

During the past 12 months, seen a profession to address mental/emotional concerns? _____

Had a significant life event that continues to affect the camper’s life? _____

Please explain yes answers in space below: _____

Medications

This person takes NO medications on a routine basis

Please list all prescription and non- prescription medications. All medications must be brought in the original container, the dosage, frequency of administration and the prescribing physician (if applicable)

Medication _____	Dosage _____	Specific times taken each day _____
Reason for taking _____		
Medication _____	Dosage _____	Specific times taken each day _____
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Reason for taking _____		
Medication _____	Dosage _____	Specific times taken each day _____
Reason for taking _____		
Attach additional pages for medications, Identify any medications taken during the school year that participant does/may not take during the summer: _____ _____		

List any additional information about the participant’s behavior and physical, emotional, or mental health about which the camp should be aware. _____

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

I have examined _____ on date _____

Height _____ Weight _____ Blood Pressure _____

I certify I have, today, reviewed the health history and examined the above applicant is is not able to participate in an active camp program. The above applicant is under care of a physician for the following conditions: _____

RECOMMENDATIONS AND/OR RESTRICTIONS AT CAMP

Treatment to be continued at camp _____

Allergies _____

Medically-prescribed meal plan or dietary restrictions _____

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

Any limitation or restriction on camp activities _____

Additional information for health care staff at the camp _____

<p>Signature of Licensed Medical Personnel _____</p> <p>Printed _____ Title _____</p> <p>Address _____</p> <p>Phone _____ Date _____</p>

***** DO NOT WRITE BELOW THIS LINE FOR CAMP FLOYD ROGERS USE ONLY*****

Opening day screening _____ Time _____ am/pm

Meds received _____

Current health needs identified _____

Observation notes _____

Updates/additions to health history Yes No None required

Screened by _____