

**CAMP HEALTH HISTORY AND EXAM EMERGENCY CONTACT INFORMATION**

The information on this form is gathered to assist us in identifying appropriate care. It is not part of the camper or staff acceptance process.

**Please print. Use black or blue ink or type.** This form, except for the "Health Care Recommendations by Licensed Medical Personnel" on page 2, is to be filled in by custodial parent/guardian of minor or by adult camp staff member.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address City State ZIP area code number

Grade completed \_\_\_\_\_ Race/Ethnic (Girl Scouts only): \_\_\_\_\_ American Indian or Alaskan Native \_\_\_\_\_ Asian or Pacific Islander  
Black White Other Also of Spanish/Hispanic Origin

Custodial Parent/Guardian (or Spouse) \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Name area code number

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address City State ZIP area code number

**Emergency Contact: If the custodial parent/guardian or spouse is not available, who do you want us to contact in an emergency?**

Emergency Contact \_\_\_\_\_  
Name Relationship to Participant

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Street Address City State ZIP area code number

Business Address \_\_\_\_\_ Day/Cell Phone \_\_\_\_\_  
Street Address City State ZIP area code number

Alternate Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
area code number area code number

Address \_\_\_\_\_ Relationship to Participant \_\_\_\_\_  
Street Address City State ZIP

**GENERAL QUESTIONS** (Explain "yes" answers on the side.)

Has/does the participant:	Yes	No	Yes	No
1. Had any recent injury, illness or infectious disease? .....	___	___	17. Ever had problems with joints (e.g., knees) ?....	___
2. Have a chronic or recurring illness/condition? .....	___	___	18. Have an orthodontic appliance being brought to camp? .....	___
3. Ever been hospitalized? .....	___	___	19. Have any skin problems (e.g., itching, acne)?	___
4. Ever had surgery? .....	___	___	20. Have diabetes ? .....	___
5. Have frequent headaches? .....	___	___	21. Have asthma? .....	___
6. Ever had a head injury? .....	___	___	22. Have mononucleosis in the past 9 months? ..	___
7. Ever been knocked unconscious?.....	___	___	23. Had problems with diarrhea/constipation? ....	___
8. Wear glasses, contacts or protective eye wear? ....	___	___	24. Have problems with sleepwalking? .....	___
9. Ever had frequent ear infections? .....	___	___	25. If female, have an abnormal menstrual history?	___
10. Ever passed out during or after exercise? .....	___	___	26. Have a history of bed-wetting? .....	___
11. Ever been dizzy during or after exercise? .....	___	___	27. Have an eating disorder? .....	___
12. Ever had seizures? .....	___	___	28. Ever had emotional difficulties for which professional help was sought? .....	___
13. Ever had chest pain during or after exercise? .....	___	___	29. Ever had head lice? .....	___
14. Ever had high blood pressure? .....	___	___	30. Have tattoos and/or body piercings? .....	___
15. Ever been diagnosed with a heart murmur? .....	___	___		
16. Ever had back problems? .....	___	___		

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

Diseases participant has had	Allergies		Please describe current physical, mental or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp:
___ Measles	___ Hay Fever	Details of any Allergies. List allergic reaction and management of the reaction: _____	_____
___ Chicken Pox	___ Poison Ivy		
___ German measles	___ Insect stings		
___ Mumps	___ Penicillin		
___ Hepatitis	___ Medications (list) _____		
	___ Foods (list) _____		

Suggestions from parents/any activity restrictions at camp/dietary restrictions \_\_\_\_\_  
 Activities from which camper/staff should be exempted for health reasons (please explain): \_\_\_\_\_

**AUTHORIZATION FOR HEALTHCARE:** This health history is correct and complete as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the camp:

- To provide ongoing health care.
- To receive emergency medical and surgical treatment and to be hospitalized, if necessary. It is understood every effort will be made to contact me or the person noted above before taking action.
- To disclose health information to appropriate camp staff and to medical care providers.

Signature of custodial parent/guardian or camp staff member \_\_\_\_\_ Date \_\_\_\_\_

**Required**

I understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor \_\_\_\_\_ Date \_\_\_\_\_

Participant's Name \_\_\_\_\_

**Insurance Information**

Is the participant covered by family medical/hospital insurance? \_\_\_Yes \_\_\_No  
If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_  
Carrier Address \_\_\_\_\_  
Name of insured \_\_\_\_\_ Relationship to participant \_\_\_\_\_  
Insurance ID number \_\_\_\_\_  
  
Name of family physician \_\_\_\_\_ Phone number including area code \_\_\_\_\_  
Address \_\_\_\_\_  
Name of family dentist/orthodontist \_\_\_\_\_ Phone number including area code \_\_\_\_\_  
Address \_\_\_\_\_

**IMMUNIZATION HISTORY**

Please give date (month/year) for last immunization for:  
Date Vaccine  
\_\_\_\_\_ DPT: Diphtheria, Tetanus, Pertussis  
\_\_\_\_\_ Td: Tetanus Booster (**required**)  
\_\_\_\_\_ MMR: Mumps, Measles, Rubella  
\_\_\_\_\_ IVP/OPV: Polio  
\_\_\_\_\_ Hib: H.influenzae, type b  
\_\_\_\_\_ HepB: Hepatitis B  
\_\_\_\_\_ Date of last TB Mantoux test  
Result \_\_\_\_\_

Use this space to provide any additional information about the participant's behavior and physical, emotional, or medical health about which the camp should be aware. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PHYSICIAN'S STATEMENT**

If there are religious objections to physical examinations, the custodial parent or legal guardian shall complete the general information on the health history and sign the custodial parent consent statement to the effect that the individual is in good health. The form will also be signed by a church official indicating membership in the religious group named.

**Health Care Recommendations by Licensed Medical Personnel**

I have examined the above camp participant. Date of last examination: \_\_\_\_\_

BP \_\_\_\_\_ 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 condition(s): \_\_\_\_\_  
\_\_\_\_\_

Current treatment at the time of this report includes (*include current medications*) \_\_\_\_\_  
\_\_\_\_\_

**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 \_\_\_\_\_ Date \_\_\_\_\_

**Required**

Printed \_\_\_\_\_ Title \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ area code \_\_\_\_\_ phone \_\_\_\_\_



Participant's Name \_\_\_\_\_

### PERMISSION TO TREAT

The following is a list of common over-the-counter medications which have been recommended by our consulting doctor and are available at the camp for the treatment of minor afflictions. The dosage will be determined by the camper's age and directions listed on each medication. Please indicate whether or not these treatments may be given for each condition listed.

**\*\*Reminder\*\*** We will contact you immediately if illness develops or emergency treatment is required!

<u>YES</u>	<u>NO</u>	<u>MEDICATION</u>	<u>CONDITION</u>
_____	_____	First Aid Cream	Treat wound - not severe
_____	_____	Tylenol	Relief of minor headache or fever.
_____	_____	Tylenol	Sore throat
_____	_____	Tylenol	Earache
_____	_____	Tylenol	Menstrual cramps
_____	_____	Tylenol	Muscle aches and strains
_____	_____	Ibuprofen	Pain or fever
_____	_____	Dimetapp	Cough
_____	_____	Pepto-Bismol	Diarrhea
_____	_____	Pepto-Bismol	Nausea, upset stomach
_____	_____	Kaopectate	Diarrhea
_____	_____	Pepcid AC	Heartburn, acid indigestion
_____	_____	Milk of Magnesia	Constipation
_____	_____	Benedryl	Mild swelling and itching due to allergic reaction to insect sting
_____	_____	Salt water gargle	Sore throat
_____	_____	Sudafed	Relieve congestion or runny nose
_____	_____	Solorcaine	Treat sunburn
_____	_____	Caladryl	Treat poison ivy

I authorize the camp personnel to administer medication to above camper while in attendance at Camp Molly Lauman.

\_\_\_\_\_  
Custodial Parent/Guardian Signature

\_\_\_\_\_  
Date

#### **MEDICATIONS PROCEDURE PLEASE READ**

\* Medication brought to camp must be given to camp personnel at check-in. **DO NOT PACK MEDICATION IN SUITCASE.** Please place the medication in a clear ziploc bag. Make sure each container of medication is labeled with the camper's name before placing it in the clear ziploc bag. Label the outside of the ziploc bag with the camper's name.

\*Ohio law requires that a physician's signature be on file in order that designated camp personnel be allowed to administer medicine to campers. If your child is bringing prescription medication to camp, the prescribing physician needs to sign the form on page 3.

\*\* If your child needs an inhaler, the inhaler itself needs to be labeled with the camper's name. If the inhaler is to be carried with her at all times, the prescribing physician needs to sign a statement to that effect. We recommend she carry the inhaler in a small waist pack that zippers shut and not in a pants pocket.