

Health History and Examination Form for Children, Youth, and Adults Attending Camps

Dates of Camp Attendance _____

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 (first three pages) must be filled out by parents/guardians of minors or by adults themselves. Update required annually. Health exam (back page) must be completed by approved licensed medical personnel at least every two years.

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

Home address _____
Street address City State Zip

Social security number of participant _____ Gender: Male Female
(needed for insurance)

Custodial parent/guardian _____ Phone _____

Home address _____
(if different from above) 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 _____

If not available in an emergency, notify:

Name _____

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 # _____

Important — These boxes must be complete for attendance*

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 insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

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/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.

Year

Cabin or Group

Name

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.

Describe reaction and management of the reaction.

Medication allergies (list)

_____	_____
_____	_____
_____	_____
_____	_____

Food allergies (list)

_____	_____
_____	_____
_____	_____

Other allergies (list) — include insect stings, hay fever, asthma, animal dander, etc.

_____	_____
_____	_____
_____	_____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription 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 follows:

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 _____		
Med #4 _____	Dosage _____	Specific times taken each day _____
Reason for taking _____		
Med #5 _____	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: _____

General Questions (Explain “yes” answers below.)

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

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

Which of the following has the participant had?	Please give all dates of immunization for:							
	Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Measles	DTP		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Chicken pox	TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German measles	Tetanus		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Polio		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	MMR		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Measles		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Mumps		_____	_____	_____	_____	_____	_____
	or Rubella		_____	_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B		_____	_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

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 family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (Girl Scouts– North Carolina Coastal Pines requirements specify exams within 24 months of camp attendance.)

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 conditions

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 (activities include but not limited to swimming, canoeing, sailing, field games, hiking, etc.)

Additional information for health care staff at the camp

Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

Standing Medication Orders

Parent/Guardian: please review the following medications that you may allow the health supervisor to provide for your child based on clinical symptoms and presentation. My daughter has permission to take or use the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Tylenol/Acetaminophen | <input type="checkbox"/> Advil/Ibuprofen | <input type="checkbox"/> Sudafed/decongestant |
| <input type="checkbox"/> Benadryl/antihistamine | <input type="checkbox"/> Pepto Bismol | <input type="checkbox"/> Swimmers' Ear/alcohol vinegar solution |
| <input type="checkbox"/> Tums/antacid | <input type="checkbox"/> Robitussin/expectorant | <input type="checkbox"/> Other medications as deemed necessary |

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Signature of parent/guardian _____

Printed Name: _____ Date: _____