



2018 Summer Camp Health Form



PLEASE NOTE - A complete, signed 2018 Health Form is required for ALL participants.

| | | | | | | |
|------------------------------------|---|-------|----------|---------------|-----|-------|
| Camper Name (Last, First, Initial) | Name & Relationship of parent/guardian completing this form | | | Daytime Phone | | |
| Address (Street & Number) | City or Town | State | Zip Code | Date of Birth | Age | Grade |

EMERGENCY CONTACT INFORMATION

Relationship Key: M = Mother F = Father SM = Stepmother SF = Stepfather GP = Grandparent O = Other

| NAME | RELATIONSHIP | DAYTIME PHONE | EVENING PHONE | CELL PHONE |
|------|--------------|---------------|---------------|------------|
| | | | | |
| | | | | |
| | | | | |

Are there any legal custodial issues we should be aware of? No Yes If yes, please explain: _____

INSURANCE INFORMATION (Please attach a copy of your medical insurance card)

Is the participant covered by family medical/hospital insurance? Yes No

If yes, indicate carrier or plan name _____ Group # _____

Carrier address _____

Name of insured _____ Relationship to Participant _____

Social security number of policy holder or insurance ID number _____

HEALTH HISTORY - Please check all that apply.

| CRONIC / RECURRING ILLNESS | OTHER HEALTH CONDITIONS | |
|--|--|--|
| <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> Ear Infection <input type="checkbox"/> Heart defect / disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Kidney disease <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Musculoskeletal disorders <input type="checkbox"/> Seizures / Epilepsy <input type="checkbox"/> Sinusitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other (Please Specify) _____ | <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Bedwetting <input type="checkbox"/> Behavioral disturbances <input type="checkbox"/> Constipation <input type="checkbox"/> Depression <input type="checkbox"/> Diarrhea <input type="checkbox"/> Emotional disturbances <input type="checkbox"/> Fainting <input type="checkbox"/> Frequent colds <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Frequent sore throats <input type="checkbox"/> Frequent stomach aches | <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Menstrual cramps <input type="checkbox"/> Motion sickness <input type="checkbox"/> Night terrors <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Pediculosis (lice) <input type="checkbox"/> Sleepwalking <input type="checkbox"/> Wears contacts/glasses <input type="checkbox"/> Wears orthodontic device <input type="checkbox"/> Others (Specify) _____ |

OTHER INFORMATION

Has your daughter been taught about menstruation? Yes No N/A

Has your daughter begun menstruation? Yes No N/A

Specify any special dietary regimen to be followed: _____

Specify activities to be encouraged: _____

Specify activities to be restricted: _____

List necessary adaptations or limitations: _____

In the last year, has the camper had:

an injury/illness requiring medical attention

a surgical operation or fracture

restrictions from participation in P.E. class

an illness lasting longer than 5 days

hospital treatment

exposure to a contagious disease

Is participant currently:

receiving psychological counseling

under a physician's care

restricted from physical activity

taking prescription medication
(Complete reverse side)

taking over the counter medication
(Complete reverse side)

Please explain any items checked above. Give dates and include any information that would be helpful to camp staff in relation to these health conditions. Add an additional sheet if needed.

ALLERGIES

| | |
|---|--|
| List all known (medication, food, insect stings, hay fever, etc.) | Describe reaction & management of the reaction |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

****Attach additional pages for more allergies****

The following medications are provided at camp. They will be administered under the designated health supervisor's supervision; dosage as appropriate for weight and/or age. We encourage your permission to use them by placing an "X" in the box beside each.

- | | | | |
|--|--------------------------------------|--|--|
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Antacid | <input type="checkbox"/> Anti-diarrheals | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Decongestant | <input type="checkbox"/> Expectorant | <input type="checkbox"/> Diphenhydramine | <input type="checkbox"/> Ibuprofen |

PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS BROUGHT FROM HOME (Please complete below)

| MEDICATION | CONDITION TREATED | DOSAGE | TIME OF DAY | TAKEN WITH FOOD? |
|------------|-------------------|--------|--|------------------|
| | | | <input type="checkbox"/> B-fast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> As needed <input type="checkbox"/> Other | |
| | | | <input type="checkbox"/> B-fast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> As needed <input type="checkbox"/> Other | |
| | | | <input type="checkbox"/> B-fast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> As needed <input type="checkbox"/> Other | |

RECORD OF IMMUNIZATION

| | Date of Last Immunization | | Date of Last Immunization |
|----------------------------|---------------------------|------------------------------|----------------------------------|
| DTaP | _____ | Diphtheria | _____ |
| Pertussis (Whooping Cough) | _____ | Tetanus (within last 10 yrs) | _____ |
| Td | _____ | Oral polio / IPV | _____ |
| Measles | _____ | Mumps | _____ |
| Rubella | _____ | Hib | _____ |
| Hep B | _____ | Tuberculin Test | Yr last given _____ Result _____ |

HEALTH STATEMENT

This health record, including the allergy and medicine information on this form is complete and accurate. My camper has my permission to engage in all prescribed activities, including strenuous activities such as hiking, swimming, climbing hills, except as noted by me and the examining MD/DO/ARNP. I give my permission for the camp staff to provide first-aid and to obtain in-camp or out-of-camp healthcare treatment for my camper should the need arise. In case of emergency, healthcare treatment beginning with first-aid provided by designated camp staff, EMT and local clinic/hospital staff will be given under the supervision the camp staff. I understand there is also a HealthCare Waiver available, for adult (18+ yrs.) staff and adult campers to sign if desired. Emergency contacts on the opposite side of this form will be contacted as soon as possible.

HEALTH INFORMATION PRIVACY STATEMENT

This health form is for health care concerns at Pilgrim Heights camp sessions only. All records will be handled by staff / volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the Director/Dean at each camp. Minimal necessary information will be shared with other staff / volunteers in order to provide adequate participant safety and health care. The health form will be retained by Pilgrim Heights Camp and Retreat Center until it is destroyed. All forms / records with noted treatment will be retained for seven years past the age of maturity of the participant. I have read the above procedures for handling the health form and agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

SIGNATURE OF PARENT OR GUARDIAN _____ **DATE** _____

*****PHYSICAL EXAMINATION*****

NOTE TO PHYSICIAN: Must be within the last year.

Required for any individual participant attending program. However, adult program participants do not need to complete the following section.

| DATE OF HEALTH EXAMINATION: _____ Nose _____ Throat _____ Teeth _____ Heart _____ Lungs _____ Abdomen _____ Genitalia _____ Hernia _____ Skin _____ Musculoskeletal _____ General Physical / Mental / Psychological status _____ Urinalysis* _____ HGB* _____ Other Notes: _____ _____ _____ Physician's comments and/or recommendations. Give details or indicate management or significant illnesses. _____ _____ _____ | Height _____ Weight _____ B.P. _____ Appearance / Nutrition _____ | | | | | | | | |
|--|---|---------------------|---------------|-----------|-------------|---------------------|---------------------|-------------|--|
| | <table border="1"> <thead> <tr> <th></th> <th>W/OUT GLASSES</th> <th>W/GLASSES</th> </tr> </thead> <tbody> <tr> <td>EYES</td> <td>R 20/____ L 20/____</td> <td>R 20/____ L 20/____</td> </tr> <tr> <td>EARS</td> <td colspan="2">Hearing Right _____ Hearing Left _____</td> </tr> </tbody> </table> | | W/OUT GLASSES | W/GLASSES | EYES | R 20/____ L 20/____ | R 20/____ L 20/____ | EARS | Hearing Right _____ Hearing Left _____ |
| | W/OUT GLASSES | W/GLASSES | | | | | | | |
| EYES | R 20/____ L 20/____ | R 20/____ L 20/____ | | | | | | | |
| EARS | Hearing Right _____ Hearing Left _____ | | | | | | | | |
| | Which of the following, if any, has the patient had? <input type="checkbox"/> Measles <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Mumps <input type="checkbox"/> Hepatitis <input type="checkbox"/> German Measles This person is in satisfactory condition and may engage in all usual activities, except as noted. Name of Licensed MD/DO or ARNP: _____ Signature of Licensed MD/DO or ARNP: _____ Address _____ Phone _____ Date _____ | | | | | | | | |

*Not required for every health exam.