2017 Summer Camp Health Form

PLEASE NOTE - A complete, signed 2017 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

- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Diabetes
- ☐ Ear Infection
- ☐ Heart defect / disease
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Mononucleosis
- ☐ Musculoskeletal disorders
- ☐ Seizures / Epilepsy
- ☐ Sinusitis
- ☐ Tuberculosis
- ☐ Other (Please Specify)

_____

OTHER HEALTH CONDITIONS

- ☐ ADD/ADHD
- ☐ Bedwetting
- ☐ Behavioral disturbances
- ☐ Constipation
- ☐ Depression
- ☐ Diarrhea
- ☐ Emotional disturbances
- ☐ Fainting
- ☐ Frequent colds
- ☐ Frequent headaches
- ☐ Frequent sore throats
- ☐ Frequent stomach aches
- ☐ Hearing Impairment
- ☐ Menstrual cramps
- ☐ Motion sickness
- ☐ Night terrors
- ☐ Nosebleeds
- ☐ Pediculosis (lice)
- ☐ Sleepwalking
- ☐ Wears contacts/glasses
- ☐ Wears orthodontic device
- ☐ 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 then 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 heath 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.

☐ Acetaminophen ☐ Antacid ☐ Anti-diarrheals ☐ Antihistamine
☐ Decongestant ☐ Expectorant ☐ Diphenhydramine ☐ Ibuprofen

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

MEDICATION	CONDITION TREATED	DOSAGE	TIME OF DAY	TAKEN WITH FOOD?
			☐ B-fast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As needed ☐ Other	
			☐ B-fast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As needed ☐ Other	
			☐ B-fast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As needed ☐ Other	

RECORD OF IMMUNIZATION

	Date of Last Immunization		Date of Last Immunization
DTaP	_____	Diptheria	_____
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 heath 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.

_____
_____
_____

*Not required for every health exam.

Height _____ Weight _____ B.P. _____
Appearance / Nutrition _____

	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?
☐ Measles ☐ Chicken Pox ☐ Mumps
☐ Hepatitis ☐ 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 _____