HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

I examined this individual on _____ . (ACA accreditation 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

_____

_____

Additional information for health care staff at the camp

_____

_____

Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Address _____ Phone _____

City, State, Zip _____ Date _____

for camp use only

SCREENING RECORD

Date screened _____

Time _____ am pm

Meds received _____

_____

Updates/additions to health history noted ☐ Yes ☐ No ☐ None required

Current health needs identified _____

_____

Observational notes _____

_____

Screened by _____

Year _____

Cabin or Group _____

Camper Name _____

Dates of Camp Attendance: _____

HEALTH HISTORY & EXAMINATION FORM FOR CHILDREN, YOUTH & ADULTS ATTENDING BRENDA SCHULTZ SPORTS CAMP

The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parent/guardian of minors or by adults themselves. Updates required annually. Health exam (last page) must be completed by approved licensed medical personnel at least every two years.

CAMPER NAME (last, first, middle initial) _____ Birthdate _____ Age (at time of camp) _____

Home Address _____ Phone _____

City, State, Zip _____

Social Security Number of Camper _____ Gender ☐ Male ☐ Female

CUSTODIAL PARENT/GUARDIAN _____ Phone _____

Parent/Guardian Address (if different from Camper) _____

City, State, Zip _____

Business Address _____ Phone _____

City, State, Zip _____

SECOND PARENT/GUARDIAN or Emergency Contact _____ Phone _____

Address (if different from Camper) _____

City, State, Zip _____

Business Address _____ Phone _____

City, State, Zip _____

IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY

Name _____ Relationship _____

Address _____ Phone _____

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*

Parent/Guardian Authorization: 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 that 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/Staff _____

Printed Name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of Camper/Staff _____ Date _____

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

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 adminstration.

☐ Camper takes NO medications on a routine basis.

☐ Camper takes the 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 _____

Attach additional pages for more medications. Identify any medications taken during the school year that particpant does/may not take during the summer:

_____

Restrictions (The following restrictions apply to this individual.)

DIETARY

☐ Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs
☐ Does not eat poultry ☐ Does not eat seafood ☐ Does not eat dairy products
☐ Other (describe) _____

_____

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

_____
_____
_____

GENERAL QUESTIONS (Explain "Yes" answers below.)

Has/does the Camper:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐	17. Ever had problems with joints (e.g. knees, ankles)?	☐	☐
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, rash, acne)?	☐	☐
4. Ever had surgery?	☐	☐	20. Have diabetes?	☐	☐
5. Have frequent headaches?	☐	☐	21. Have asthma?	☐	☐
6. Ever had a head injury?	☐	☐	22. Had mononucleosis in the past 12 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. Ever had 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?	☐	☐			
14. Ever had high blood pressure?	☐	☐			
15. Ever been diagnosed with a heart murmur?	☐	☐			
16. Ever had back problems?	☐	☐			

Please explain any "Yes" answers, noting the number of the questions.

_____
_____
_____
_____
_____

Which of the following has the Camper had?

☐ Measles
☐ Chicken Pox
☐ German Measles
☐ Mumps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

TB Mantoux Test
Date of last test _____
Result: ☐ Positive ☐ Negative

Please give all dates of immunization for:

Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diptheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
M M R	_____	_____				
or Measles	_____	_____				
or Mumps	_____	_____				
or Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Varicella (chicken pox)	_____	_____				

Use this space to provide any additional information about the Camper's behavior and physical, emotional, or mental health about which the Camp should be aware.

_____
_____
_____
_____
_____

Name of family physician _____ Phone _____
Address _____
City, State, Zip _____
Name of family dentist/orthodontist _____ Phone _____
Address _____
City, State, Zip _____