

Health History and Examination Form for Campers and Staff
(developed by the American Camping Association, adapted by Harand Camp)

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 or 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.*

Year of attendance: _____

Attending: 1st session only 2nd session only both sessions

Name: _____ Birth Date: _____ Age at camp: _____

Home address: _____

Social Security Number: _____ Gender: _____

Custodial parent/guardian: _____ Phone: _____

Home address (if different): _____

Business address: _____ Phone: _____

Second parent or guardian or emergency contact: _____

Home address (if different): _____ Phone: _____

Business address: _____ Phone: _____

If not available in an emergency, notify:

Name: _____

Relationship to camper: _____ Phone: _____

Home address: _____

Insurance Information

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

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

Please attach a clear photocopy of front and back of health insurance card and attach.

Parent/Guardian Authorization – Required for Attendance*

This health history is correct and complete as far as I know. The person described herein 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 medication, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or 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. The completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult staff member _____

Printed name _____ Date _____

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

Signature of camper or adult staff member _____ Date _____

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

Health History

The following information must be filled in by the parent/guardian or staff member. The intent of this information is to provide camp health care persons 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

_____	_____
_____	_____
_____	_____

Food allergies

_____	_____
_____	_____

Other allergies – include insect stings, hay fever, asthma, animal dander, etc.

_____	_____
_____	_____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at ca. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, 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 _____		

Attach additional pages for more medications, if applicable.

Identify any medications taken during the school year that person does/may not take during the summer:

Each participant must have on file an up-to-date Medication Form (page 5). Please be sure to fill that out regardless of what is filled out in this section.

RESTRICTIONS

The following restrictions apply to this individual.

DIETARY

- | | | |
|---|--|---|
| <input type="radio"/> Does not eat red meat | <input type="radio"/> Does not eat pork | <input type="radio"/> Does not eat eggs |
| <input type="radio"/> Does not eat poultry | <input type="radio"/> Does not eat seafood | <input type="radio"/> 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 participant:	Yes	No	Yes	No
1. Had any recent injury, illness or infectious disease?.....	o	o	16. Ever had back problems?.....	o
2. Have a chronic or recurring illness/ condition?.....	o	o	17. Ever had problems with joints (knees, ankles,...)?...	o
3. Ever been hospitalized?.....	o	o	18. Have an orthopedic appliance being brought to camp?.....	o
4. Ever had surgery?.....	o	o	19. Have any skin problems (itching, rash, acne,...)?.....	o
5. Have frequent headaches?.....	o	o	20. Have diabetes?.....	o
6. Ever had a head injury?.....	o	o	21. Have asthma?.....	o
7. Ever been knocked unconscious?.....	o	o	22. Had mononucleosis in the past 12 months?.....	o
8. Wear glasses, contacts or protective eye wear?.....	o	o	23. Had problems with diarrhea/constipation?.....	o
9. Ever had frequent ear infections?.....	o	o	24. Have problems with sleepwalking?.....	o
10. Ever passed out during or after exercise?.....	o	o	25. If female, have an abnormal menstrual history?.....	o
11. Ever been dizzy during or after exercise?.....	o	o	26. Have a history of bed wetting?.....	o
12. Ever had seizures?.....	o	o	27. Ever had an eating disorder?.....	o
13. Ever had chest pain during or after exercise?.....	o	o	28. Ever had emotional difficulties for which professional help was sought?.....	o
14. Ever had high blood pressure?.....	o	o		
15. Ever been diagnosed with a heart murmur?.....	o	o		

Please explain any "yes" answers, noting the number preceding the question.

Which of the following has the participant had? Check all that apply.

Measles Chicken Pox German Measles Mumps Hepatitis
 TB Mantoux Test: Date of Last Test: _____ Result: Positive Negative

Please give all dates of immunization for:

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
Or Measles	_____	_____	_____	_____	_____	_____
Or Mumps	_____	_____	_____	_____	_____	_____
Or Rubella	_____	_____	_____	_____	_____	_____
Haemophilus influenza B	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____	_____
BCG	_____	_____	_____	_____	_____	_____

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 _____

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted on Page 2.

Signed _____ Printed _____ Date _____

Results of Examination by Licensed Medical Professional

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

BP _____ Weight _____ Height _____

In my opinion, the above camper/staff member is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

Current treatment at the time of this report includes:

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 _____ Date _____

For camp use only

Screening Record

Date screened _____ Time _____

Meds received _____

Updates/additions to health history noted Yes No None required

Current health needs identified _____

Observational Notes _____

Screened by _____

Medication Form

Permission for health care staff to dispense medications to camper or staff member

Please read the following information about medication procedures.

Parents/guardians will have an opportunity to turn in any medications during camp registration at the beginning of each session. Campers may also turn in medications directly to the health care staff during the first night's health screening.

Prescription medications must be in a prescription container labeled with:

1. Camper's or Staff Member's Name
2. Doctor's Name
3. Name of medication
4. Dosage to be given
5. Frequency of distribution

Over-the-counter medication must:

1. Be in original container
2. Have legible directions
3. Have child's name on container

Please fill out the following information:

My child, _____, has permission to take the following medications while attending Harand Camp of the Theatre Arts

Name of medication _____

Dosage of medications: _____

Frequency: _____ 1 per day
 _____ 2 per day
 _____ 3 per day
 _____ 4 per day
 _____ only when needed

Signature of parent/guardian/adult staff member: _____

Date: _____