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: o 1st session only o 2nd session only o 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? o Yes o 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 personn 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 adminstration.

o This person takes NO medications on a routine basis.

o 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

o Does not eat red meat
o Does not eat poultry
o Does not eat pork
o Does not eat seafood
o Does not eat eggs
o Does not eat dairy products

o 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
1. Had any recent injury, illness or infectious disease?	o	o
2. Have a chronic or recurring illness/ condition?	o	o
3. Ever been hospitalized?	o	o
4. Ever had surgery?	o	o
5. Have frequent headaches?	o	o
6. Ever had a head injury?	o	o
7. Ever been knocked unconscious?	o	o
8. Wear glasses, contacts or protective eye wear?	o	o
9. Ever had frequent ear infections?	o	o
10. Ever passed out during or after exercise?	o	o
11. Ever been dizzy during or after exercise?	o	o
12. Ever had seizures?	o	o
13. Ever had chest pain during or after exercise?	o	o
14. Ever had high blood pressure?	o	o
15. Ever been diagnosed with a heart murmur?	o	o
16. Ever had back problems?	o	o
17. Ever had problems with joints (knees, ankles,...)?	o	o
18. Have an orthopedic appliance being brought to camp?	o	o
19. Have any skin problems (itching, rash, acne,...)?	o	o
20. Have diabetes?	o	o
21. Have asthma?	o	o
22. Had mononucleosis in the past 12 months?	o	o
23. Had problems with diarrhea/constipation?	o	o
24. Have problems with sleepwalking?	o	o
25. If female, have an abnormal menstrual history?	o	o
26. Have a history of bed wedding?	o	o
27. Ever had an eating disorder?	o	o
28. Ever had emotional difficulties for which professional help was sought?	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.

o Measles o Chicken Pox o German Measles o Mumps o Hepatitis

TB Mantoux Test: Date of Last Test:_____ Result: o Positive o 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 eng 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 O is O. 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 O Yes O No O 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:_____

Summer Camp and Conference Overnight
Registration Form and Health Form

This form must be completed before campers can participate in any events at Carthage College

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Camp/Conference Name:_____ Date of Camp:_____ to _____

Last Name:_____ First Name:_____

Home Address:_____
(Street) (City) (State) (Zip)

Home Telephone Number: (___)_____ Date of Birth: _____
(Month, Day, Year)

E-mail:_____

Sex: O Male O Female Check One: O Camper O Adult Leader/Chaperone

Emergency Contact:_____ Relationship:_____

Home Telephone: (___)_____ Work Telephone: (___)_____

Cell Phone: (___)_____

Address:_____
(Street) City State Zip

CONSENT FOR MEDICATION ADMINISTRATION AND MEDICAL TREATMENT

Parents or Legal Guardian:

If your son, daughter, or ward will be under the age of 18 while at Carthage College, it is camp policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device can be self-administered or be administer by designate camp health staff with the exception that controlled drugs (i.e. Codeine, Ritalin, Adderall, Dexedrine, etc.) must, by law, be administered by camp health staff.

All prescription medication must be in the original medicine bottle and labeled with the camper's name, doctor's name, medication name, dosage, prescription number, date prescribed, and instructions. You must also complete the form below:

O No medication(s) have been brought to camp.
O I want the medication or medical devices self-administered (age 14 or above only).

(over)

O I want the medication or medical device administered by the designated camp staff. However, a limited amount of medication for life-threatening conditions may be carried by my son/daughter/ward (i.e. bee sting kit, inhaler, insulin syringe).

If your son, daughter, or ward will be under the age of 18 years while at camp, it is the policy to secure your consent for all of the following. By signing below,

- I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- I am stating that I am aware of and accept the risk inherent in the program activity
- I attest that all information on this form is correct.
- I agree to hold harmless and indemnify the Board of Trustees of Carthage College, their officers, agents, and employees for any and all liability, loss, damages, costs, or expenses which are sustained, incurred, or required arising out of the actions of my son, daughter, or ward in the course of the camp/event.

Date of last Tetanus Booster: _____

Medications Camper will be taking at camp:

Name of Medication	Reason	Dosage (mg)	Time of day given	Prescribing Physician & Phone Number

Health Conditions (Check)

O Asthma
O Diabetes
O Epilepsy
O Other Conditions_____

Allergies (check & list specifics)

O Insect stings_____
O Foods _____
O Medications _____
O Other Allergies _____

_____ _____

Signature of Participant, Parent or Legal Guardian Date