Health History and Examination Form for Children, Youth and Adults Attending Camps

FM 08N

Suggested for resident camp use.

Developed and approved by
American Camping Association
American Academy of Pediatrics
Expires 12/31/03

Dates of Camp Attendance _____

Mail this form to the address below by _____ (date)

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 of 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.

Name _____ Birth date _____ Age at camp _____
(Last, First, Middle)

Home address _____ Gender: ☐ Male ☐ Female
(Street address, City, State, Zip)

Social security number of participant _____ Phone _____

Custodial parent/guardian _____

Home address _____ Phone _____
(If different from above) (Street address, City, State, Zip)

Business address _____
(Street address, City, State, Zip)

Second parent or guardian or emergency contact _____ Phone _____

Address _____ Phone _____
(Street address, City, State, Zip)

Business address _____

If not available in an emergency, notify:

Name _____ Phone _____

Relationship _____

Address _____
(Street address, 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 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. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staffer _____ Date _____

Printed Name _____

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

Signature of minor or adult camper/staffer _____ Date _____

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

 Revised 1990, 1992, 1994, 1995, 1996, 1998, 1999, 2000, 2001.

Year

Cabin or Group

Name

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 packaging/bottle that identifies the prescribing physician (if a nonprescription drugs) taken routinely. Bring enough prescription drug), the name of the medication, the dosage, medication to fast the entire time at camp. Keep it in the original and the frequency of administration.

O 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 pa for more medications.

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

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

0 Does not eat red meat
O Does not eat pork
O Does not eat eggs
D Does *not* eat poultry
O Does not eat seafood
O Does not eat dairy products
D Other (describe)

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

Health Care Recommendations by Licensed Medical Personnel

I examined this *Individual* on . (ACA accreditation requirements specify exams within 24 months *of* camp attendance. *Individual dual* camps may require annual exams. A new exam is not necessarily required for camp attendance.)

BP Weight Height

In my opinion, the above applicant D is D 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 Restrictons 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 am pm

Meds received

Updates/additions to health history noted D Yes O No O None required

Current health needs identified

Observational notes

Screened by

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	D
16. *Ever* had back problems?	O	D

Has/does the *participant:*	Yes	No
17. *Ever* had problems with joints {e.g., knees, ankles)?	O	O
18. Have an orthodontic appliance being brought to camp?	O	O
19. Have any skin problems (e.g., 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?	D	O
26. Have a history of bed-wetting?	D	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 of the questions.

Which *of* the following has the participant had?

- 0 Measles
- 0 Chicken pox
- 0 German measles
- 0 Mumps
- D Hepatitis A
- D Hepatitis B
- 0 Hepatitis c

TB Mantoux Test

Date of last test------'--

Result: 0 Positive 0 *Negative*

Please give all dates *of* immunization for:

Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP						
TO (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
=:· *or* Measles						
or Mumps						
. . or Rubella						
Haemophilus influenza 8						
Hepatitis B						
Varicella (chicken pox)						

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 ---------- ---------- ----------