

Health History and Examination Form For Under One Sky Camps

For Office Use Only

Dates of Attendance _____
Cabin/Group _____ County _____

Health History must be filled out by parents/guardians of minors or by adults themselves. Update required for each camp session. Health exam must be completed by an approved licensed medical personnel, either using the area at the bottom of page three of this form or by attaching a copy of a physical conducted within the past two years.

Name _____ Birth Date _____
Last First Middle

Age at Camp _____ Gender _____ Social Security Number _____

Home Address _____
Street City State Zip

Custodial Parent/Guardian _____ Phone _____

Address _____
Street City State Zip

Second Parent/Guardian _____ Phone _____

Address _____
Street City State Zip

Emergency Contact _____ Phone _____

Address _____
Street City State Zip

Insurance Information

Is the participant covered by Medicaid or family medical/hospital insurance? yes no

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

 **Please attach copy of health insurance card to form.**

Important-The following must be complete for attendance*

Parent/Guardian Authorizations: 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 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 _____

Printed Name _____ Date _____

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

Medication allergies

Describe reaction and management of the reaction.

Food allergies

Other allergies

MEDICATIONS

Please list ALL medications, even over-the-counter or nonprescription drugs, including Tylenol, Pepto-Bismol, Benadryl, etc. that may be taken. Bring enough medication to last the entire time at camp. **Keep it in the original packaging/bottle that identifies the prescribing physician (if prescription drug), the name of medication, the dosage, and the frequency of administration.**

This person takes NO medications on a routine basis

This person takes medications as follows:

Med#1	Reason	Dosage	Time taken
Med#2	Reason	Dosage	Time taken
Med#3	Reason	Dosage	Time taken
Med#4	Reason	Dosage	Time taken

This person may take the following medications as needed:

Aspirin Tylenol Ibuprofen Benadryl Pepto-Bismol Other _____

DIETARY RESTRICTIONS

PHYSICAL RESTRICTIONS

General Questions (Explain "yes" answers.)

Has/does the participant:

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 1. Had any recent injury, illness or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever been dizzy/passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever had seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 13. Ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Ever been diagnosed with a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Ever had back problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Ever had joint problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have any skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Had mononucleosis in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have problems sleepwalking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have a history of bed-wetting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain "yes" answers, noting the number of the questions.

Which of the following has the participant 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 dates of immunization for (or attach copy of record):

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

Name of Family Physician _____ Phone _____

Address _____

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. BP _____ Wt _____ Ht _____
 In my opinion, the above applicant is is not able to participate in an active camp program.

Restrictions/Recommendations:

Signature of Licensed Medical Personnel _____ Date _____

Printed _____ Title _____

Address _____ Phone _____

Screening Record: For camp use only	Date _____ Time _____
Meds received _____	
Updates/additions to Health History _____	
Current health needs identified _____	
Screened by _____	