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 ☐ Ibuprofin ☐ 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?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eyewear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever been dizzy/passed out during or after exercise?	☐	☐
11. Ever had seizures	☐	☐
12. Ever had chest pain during or after exercise?	☐	☐
13. Ever had high blood pressure?	☐	☐
14. Ever been diagnosed with a heart murmur?	☐	☐
15. Ever had back problems?	☐	☐
16. Ever had joint problems?	☐	☐
17. Have any skin problems?	☐	☐
18. Have diabetes?	☐	☐
19. Have asthma?	☐	☐
20. Had mononucleosis in the past 12 months?	☐	☐
21. Have problems sleepwalking?	☐	☐
22. Have a history of bed-wetting?	☐	☐
23. Ever had an eating disorder?	☐	☐

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/diptheria)	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____
Polio	_____	_____	_____	_____
MMR	_____	_____		
or Measles	_____	_____		
or Mumps	_____	_____		
or Rubella	_____	_____		
Haemophilus infuenza	_____	_____	_____	_____
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_____