



HEALTH HISTORY AND EXAMINATION FORM FOR CAMPERS AND STAFF UNDER 18 YEARS OF AGE

Name \_\_\_\_\_ Gender  Female  Male

Birth date \_\_\_\_\_ Age on 6/1/11 \_\_\_\_\_ Social Security # \_\_\_\_\_

Parent(s) with whom this camper/staff lives \_\_\_\_\_

Address \_\_\_\_\_

Phone numbers and Emails \_\_\_\_\_

list and label all phone numbers and emails in order of preference

Is there another parent/guardian that needs to be contacted by the Health Center?  Yes  No

Name(s) \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone Numbers and Emails \_\_\_\_\_

list and label all phone numbers and emails in order of preference

Insurance Information: attach a copy of front & back of all insurance cards and FSA or credit card

Policy Holder \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insured ID# \_\_\_\_\_ Group # \_\_\_\_\_

Physician Information (Indicate the doctor(s) we should contact if necessary)

Physician/Pediatrician \_\_\_\_\_ Phone \_\_\_\_\_

Other \_\_\_\_\_ Phone \_\_\_\_\_

PERMISSION TO PROVIDE NECESSARY TREATMENT AND TO RELEASE MEDICAL INFORMATION:

I hereby give permission to the camp to provide routine health care, administer or dispense prescription and over-the-counter medications and seek medical treatment including ordering diagnostic tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes and to provide or arrange necessary transportation for my child. I authorize any physician, nurse or health care provider to communicate with the medical staff and directors of Camp Scatico, or their designees, about my child's medical condition, treatment, and/or prognosis. I further authorize the camp medical staff to discuss any medical conditions with the directors, or their designees, or my child's counselor, when the medical staff, in its sole discretion, believes such communication to be in the best interest of my child or in the best interest of the camp community. In the event that I, or any of the contacts listed above, cannot be reached in case of an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child. This completed form may be photocopied for trips out of camp and transmitted electronically when needed. I also agree to abide by the restrictions placed on my child's camp activities.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

PARENT SIGN HERE

Name: \_\_\_\_\_

SUMMER 2011

The following information must be filled in by a parent or guardian and reviewed by a physician *within the past six months. The camp health personnel must be informed of any changes to this form upon arrival at camp.*

Place one check (✓) in the appropriate column that corresponds to each item below. *If "yes" provide details and dates:*

	Yes	No		Yes	No		Yes	No
Seasonal Influenza			Insomnia			Frequent Diarrhea Constipation		
Convulsive Disorder			Skin Rashes			Shortness of Breath		
Diabetes			Seasonal Allergies			Recent Weight Loss/Gain		
Emotional Problems			Frequent UTIs			Smoke Cigarettes		
Headaches			Anemia			Fifth's Disease / /		
Asthma			Heart Disease			Chicken Pox / /		
Bleeding Problems			Eating Disorder			Measles / /		
Depression/Anxiety			Hepatitis A,B,C			Mumps / /		
Bedwetting			Lice/Scabies			Rubella / /		

If answered "yes", please provide specific details \_\_\_\_\_

Any other history of medical conditions or surgical procedures: \_\_\_\_\_

**ALLERGIES**

*List Medication allergies*

Is camper/staff receiving regular allergy shots?  Yes  No  
Describe *reaction* and *management of the reaction*.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*List Food allergies*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Other allergies* (list: include insect stings, hay fever, asthma, animal dander, etc.)

\_\_\_\_\_  
\_\_\_\_\_

**New York State Public Health Law, Chapter 2164, requires that all campers/staff complete and submit the following information. CHECK ONE (1) BOX ONLY AND SIGN BELOW.**

My child has had the meningococcal meningitis immunization (Menomune) within the past 10 years.  
Date Received: \_\_\_\_\_

My child has had the meningococcal meningitis immunization (Menactra TM).  
Date Received: \_\_\_\_\_

I have read, or have explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

**PARENT SIGN HERE**

Name: \_\_\_\_\_

SUMMER 2011

Please give DATES for ALL DOSES for the following immunizations:

**Tetanus-Diphtheria-Pertussis (TDaP)**

- 1. Completed primary series of four doses with DTaP, DTP, DT or TD:..... / /  
Month Day Year
- 2. Booster: **TDaP** (preferred) to replace a single dose of Td for booster immunization at least  
2-5 years since last dose of Td, depending on age of patient..... / /  
Month Day Year
- (OR)**
- 3. Booster: Td within the last ten years..... / /  
Month Day Year

**Haemophilus (HIB) #1** / / / **#2** / / / **#3** / / /  
Month Day Year Month Day Year Month Day Year

**Polio #1** / / / **#2** / / / **#3** / / / **#4** / / /  
Month Day Year Month Day Year Month Day Year Month Day Year

**Varicella (chicken pox) #1** / / / **#2** / / /  
Month Day Year Month Day Year

**MMR #1** / / / **#2** / / / **or Measles #1** / / / **#2** / / /  
Month Day Year Month Day Year Month Day Year Month Day Year

**or Mumps #1** / / /  
Month Day Year

**or Rubella #1** / / /  
Month Day Year

**Hepatitis A #1** / / / **#2** / / /  
Month Day Year Month Day Year

**Hepatitis B #1** / / / **#2** / / / **#3** / / /  
Month Day Year Month Day Year Month Day Year

**Influenza #1** / / / **#2** / / /  
Month Day Year Month Day Year

Camper/Staff is under the care of a physician for the following condition/s:

\_\_\_\_\_

Current treatment at the time of this report includes: \_\_\_\_\_

Treatment to be continued at camp: \_\_\_\_\_

Description of any limitation or restriction on camp activities, including dietary restrictions: \_\_\_\_\_

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: \_\_\_\_\_

**Parent/Guardian Authorization:** This health history is correct and complete as far as I know, and my child has permission to engage in all camp activities **except as noted**. I will advise the camp of any changes to this form upon arrival at camp.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

**PARENT SIGN HERE**

Name: \_\_\_\_\_

SUMMER 2011

**TO BE COMPLETED BY PHYSICIAN WITHIN THE PAST SIX MONTHS**

Date of Exam \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ Resp \_\_\_\_\_

Head \_\_\_\_\_ Heart \_\_\_\_\_

Eyes \_\_\_\_\_ Breasts \_\_\_\_\_

Vision \_\_\_\_\_ Corrected \_\_\_\_\_ Abdomen \_\_\_\_\_

Ears \_\_\_\_\_ GYN \_\_\_\_\_

Nose \_\_\_\_\_ Lymphatics \_\_\_\_\_

Mouth & Throat \_\_\_\_\_ Extremities \_\_\_\_\_

Neck \_\_\_\_\_ Neurological \_\_\_\_\_

Chest \_\_\_\_\_ Skin \_\_\_\_\_

Date of last TST (Mantoux) \_\_\_\_\_ Result \_\_\_\_\_ If positive, date of chest-x-ray \_\_\_\_\_ Result \_\_\_\_\_

HCT Date: \_\_\_\_\_ Result: \_\_\_\_\_

Urinalysis (within last 6 months) Date: \_\_\_\_\_ Result: \_\_\_\_\_

**PRESCRIPTIONS (The camp is requiring that participants subscribe to *CampMeds*.)**

Please list all medications—*prescriptions and over-the-counter*—to be taken during camp, *even those only taken on an “as needed” basis*. Nurses cannot administer medications (prescription or over-the-counter) unless the *physician signs below*.

Name of Medication	Frequency and Dosage	Reason for Taking
_____	_____	_____
_____	_____	_____

**RESTRICTIONS ON OVER-THE-COUNTER MEDICATIONS**

Camp physicians may prescribe over the counter (OTC) medications such as Tylenol, Claritin and Cortisone Cream. List any restrictions on non-prescription medications.

\_\_\_\_\_

Indicate **ALL** medications taken during the school year that your child will **NOT** be taking during the camp season:

\_\_\_\_\_

**Licensed Medical Personnel Authorization:** I have reviewed this form in its entirety. The health history and physical exam is complete and the camper/staff has permission to engage in all activities **except as noted on previous page.**

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**PHYSICIAN SIGN HERE**

License # \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Reviewed and Screened by Camp Scatico Health Care Provider: \_\_\_\_\_  
Name Signature Date