

# Health History and Exam Form for Camp Attendance

**Mail to:** Pok-O-MacCready Camps  
PO Box 397  
Willsboro, NY 12996

This form is used to identify and provide appropriate care for the camper or staff member.

Camper Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip Code

Custodial Parents/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip Code

Work Address: \_\_\_\_\_  
Street City State Zip Code

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Second Parent/Guardian or Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip Code

Work Address: \_\_\_\_\_  
Street City State Zip Code

If not available in an emergency, notify:

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

Address: \_\_\_\_\_  
Street City State Zip Code

Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## INSURANCE INFORMATION (PLEASE SEND PHOTOCOPY OF BOTH SIDES OF CARD)

Is the participant covered by family medical/hospital insurance?  YES  NO Is this an HMO?  YES  NO

Name of Insured: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

Social Security Number of policy holder **or** insurance ID number: \_\_\_\_\_

**Is prior approval needed for care?**  YES  NO **Mandatory Contact Number** ( ) \_\_\_\_\_

Carrier or Plan Name: \_\_\_\_\_ Carrier Address: \_\_\_\_\_

### IMPORTANT – THESE BOXES MUST BE COMPLETE FOR ATTENDANCE\*

**Permission to Provide Necessary Treatment or Emergency Care:** I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests, and treatment; to release any records necessary for insurance purposes; to provide or arrange necessary related transportation for my child or me. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Health Director or Camp Director to secure and administer any 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 Staff Member: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

I understand and agree to abide by the restrictions placed on my camp activities.

Signature of camper / staff member: \_\_\_\_\_ Date: \_\_\_\_\_

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

**Over →**

## Health History

This information is used to give camp health personnel the background to provide appropriate health care. Keep a copy of the completely form for your records. Any changes to this form should be given to camp health personnel upon participant's arrival at camp. Provide complete information so that camp can be aware of the participant's needs.

**Allergies** (list all known)

Describe reaction and management of reaction.

**Medication Allergies** (list)

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**Food Allergies** (list)

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**Other Allergies** (list, including insect stings, hay fever, asthma, animal dander, etc.)

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**\*\*\*IF ALLERGIC TO BEE STINGS, PEANUTS, OR NUTS, YOU MUST PROVIDE TWO EPI-PENS**

## Current Medication

Please list all medication taken routinely (including vitamins, lactaid, nutritional supplements, etc.). Bring or send enough medication to last the entire time at camp (count pills please!). It **MUST BE** in the original packaging/bottle that identifies the child's name, the prescribing physician (if prescription drug), the name of the medication, the dosage, and the frequency of administration.

\*\*\* No medications or substances or any kind, such as vitamins, can be administered at camp unless they are listed on the pink physician form AND signed for by the physician, even if it is not a prescription medication!

This person takes NO medication on a routine basis.

### This person takes medication 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.

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

**RESTRICTIONS – The following restrictions apply to this individual**

Dietary

- Does not eat red meat       Does not eat pork       Does not eat eggs       Does not eat poultry
- Does not eat seafood       Does not eat dairy products       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:

- |   |     |    |
|---|-----|----|
| 1. Had any recent injury, illness, surgery, discomfort or infectious disease? | YES | NO |
| 2. Have a chronic or recurring illness/condition?                             | YES | NO |
| 3. Ever been hospitalized?  | YES | NO |
| 4. Ever had surgery?  | YES | NO |
| 5. Have frequent headaches?   | YES | NO |
| 6. Ever had a head injury?  | YES | NO |
| 7. Ever been knocked unconscious?   | YES | NO |
| 8. Wear glasses, contacts, or protective eyewear?                             | YES | NO |
| 9. Ever had frequent ear infections or swimmer’s ear?                         | YES | NO |
| 10. Ever passed out during or after exercise?                                 | YES | NO |
| 11. Ever been dizzy during or after exercise?                                 | YES | NO |
| 12. Ever had seizures?  | YES | NO |
| 13. Ever had chest pain during or after exercise?                             | YES | NO |
| 14. Ever been diagnosed with a heart murmur?                                  | YES | NO |
| 15. Ever had high blood pressure?   | YES | NO |
| 16. Ever had back problems?   | YES | NO |
| 17. Has any family member had a recent infection or illness?                  | YES | NO |
| 18. Ever had problems with joints (e.g. knees, ankles)?                       | YES | NO |
| 19. Have an orthodontic appliance being brought to camp?                      | YES | NO |
| 20. Have any skin problems (skin infection, history of MRSA, acne)?           | YES | NO |
| 21. Have diabetes?  | YES | NO |
| 22. Have asthma?  | YES | NO |
| 23. Had mononucleosis in the past 12 months?                                  | YES | NO |
| 24. Had problems with diarrhea/constipation?                                  | YES | NO |
| 25. Have problems with sleepwalking?  | YES | NO |
| 26. If female, have abnormal menstrual history?                               | YES | NO |
| 27. Have a history of bed-wetting?  | YES | NO |
| 28. Have an eating disorder?  | YES | NO |
| 29. Ever have emotional difficulties for which professional help was sought?  | YES | NO |
| 30. Have any reason sunscreen cannot be used?                                 | YES | NO |

**Please explain any “yes” answers, noting the number of the question, dates, and treatments.**

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Which of the following has the participant had?

- Measels
- Varicella Zoster (Chicken Pox)
- German Measles
- Mumps
- Hepatitis

Please give the dates of immunizations for full series or attach a copy of the immunization record

DPT \_\_\_\_\_  
 Booster \_\_\_\_\_  
 MMR \_\_\_\_\_  
 HIB \_\_\_\_\_  
 Meningococcal \_\_\_\_\_  
 Hepatitis B \_\_\_\_\_  
 Tetanus \_\_\_\_\_

Date of last TB PPD Test: \_\_\_\_\_ Result: \_\_\_\_\_

My child has completed all immunizations required by the state of \_\_\_\_\_ to attend school.  Yes  No

(If last tetanus shot 5-8 years ago, ask MD for advisability of immunization before camp)

Please provide any additional information about the participant's behavior and physical, emotional, or mental health about which camp should be aware. Use another sheet if necessary.

Name of Family Physician \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_

Name of Family Dentist/Orthodontist \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_

**Parent/Guardian Authorizations:** This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. **I understand that I have the responsibility to notify the Camp Health Director of any changes in the participant's medical information between the time this form is sent and the time the participant begins camp.**

Signed \_\_\_\_\_ Printed \_\_\_\_\_ Date \_\_\_\_\_

*Thank you for helping us to keep your camper healthy this summer! If you have any questions, please contact Sarah Disney at (800) 982-3538.*

