

Parent/Guardian Completes This Form

Health History and Exam Form For Camp Attendance

Mail this form to: **Pok-O-MacCready Camps**
P.O. Box 397
Willsboro, NY 12996

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

Name: _____ Birth date: _____ Age at Camp: _____
Last First Middle

Home Address: _____
Street address City State Zip

Social security number of participant: _____ Gender: Male Female

Custodial parents / guardian _____ phone _____

Home Address: _____
Street address City State Zip

Business Address: _____
Street address City State Zip

E-Mail Address: _____ Cell Phone _____

Second parent or guardian or emergency contact _____ Phone: _____

Address _____
Street address City State Zip

Business Address: _____
Street address City State Zip

If not available in an emergency, notify:

Name _____ Relationship _____

Address _____
Street address City State Zip

Phone Number _____ Business phone number _____

INSURANCE INFORMATION (PLEASE SEND A XEROX COPY OF BOTH SIDES OF CARD TO ASSIST US)

Is the participant covered by family medical / hospital insurance? Yes No Is this an HMO? Yes No

Is prior approval needed for care? Yes No **Mandatory Contact Number** () _____

Indicate carrier or plan name _____ Group # _____

Carrier address _____

Name of insured _____ Relationship to participant _____

Social security number of policy holder or insurance ID number _____

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, treatment; to release any records necessary for insurance purposes; to provide or arrange necessary related transportation for me / or my child. In the event 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 or guardian or adult camper / staffer _____	
Witness _____	Date _____

I also understand and agree to abide by the restrictions placed on my 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 4/06

Health History

The intent of this information is to provide camp health personnel the background to provide appropriate health 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.

***** IF ALLERGIC TO BEE STINGS, YOU MUST PROVIDE TWO EPI-PENS**

MEDICATION BEING TAKEN

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 the pills please!). It MUST BE in the original packaging / bottle that identifies the child's name, the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

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

_____ 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 taken during the school year that participant does / 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)

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General Questions (Explain "yes" answers below.)

Has/does the participant:

- | | | | | | |
|---|-----|----|--|-----|----|
| 1. Had any recent injury, illness, surgery, discomfort or infectious disease? | Yes | No | 18. Ever had problems with joints (e.g. knees, ankles)? | Yes | No |
| 2. Have a chronic or recurring illness/conditions? | Yes | No | 19. Have an orthodontic appliance being brought to camp? | Yes | No |
| 3. Ever been hospitalized? | Yes | No | 20. Have any skin problems (e.g. itching rash, acne)? | Yes | No |
| 4. Ever had surgery? | Yes | No | 21. Have diabetes? | Yes | No |
| 5. Have frequent headaches? | Yes | No | 22. Have asthma? | Yes | No |
| 6. Ever had a head injury? | Yes | No | 23. Had mononucleosis in the past 12 mo? | Yes | No |
| 7. Ever been knocked unconscious? | Yes | No | 24. Had problems with diarrhea/constipation? | Yes | No |
| 8. Wear glasses, contacts or protective eye wear? | Yes | No | 25. Have problems with sleep walking? | Yes | No |
| 9. Ever had frequent ear infections or swimmer's ear? | Yes | No | 26. If female, have an abnormal menstrual history? | Yes | No |
| 10. Ever passed out during or after exercise? | Yes | No | 27. Have a history of bed-wetting? | Yes | No |
| 11. Ever been dizzy during or after exercise? | Yes | No | 28. Have an eating disorder? | Yes | No |
| 12. Ever had seizures? | Yes | No | 29. Ever have emotional difficulties for which professional help was sought? | 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 recent infection or illness? | Yes | No | | | |

Please explain any "Yes" answers noting the number of the question, dates and treatments.

Which of the following has the participant had?

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

Date of last TB PPD Test _____ Result _____

Please give the dates of immunizations for full series

- DPT _____
- Last Tetanus _____ (If 5-8 years since, refer to MD for
- Booster _____ advisability of immunization before camp)
- MMR _____
- HIB _____
- Meningococcal _____
- Hepatitis B _____

My child has completed all immunizations required by the State of _____ to attend school ____ Yes ____ No

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 _____

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 person described's medical information between the times that I sent this form in and the time the participant begins camp.**

Signed _____ Printed _____ Date _____

