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 including prescription plan/information

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.

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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)

_____ _____

_____ _____

_____ _____

Food Allergies (list)

_____ _____

_____ _____

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

_____ _____

_____ _____

***IF ALLERGIC TO BEE STINGS, PEANUTS, OR NUTS, YOU MUST PROVIDE TWO EPI-PENS**
(Please attach a copy of your child's school Anaphylaxis Care Plan)

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 physical 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?(Please attach Asthma Treatment Plan)	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.

_____
_____
_____
_____

Which of the following has the participant had?

❑ Measles
❑ Varicella Zoster (Chicken Pox)
❑ German Measles
❑ Mumps
❑ Hepatitis

Date of last TB PPD Test: _____ Result: _____

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

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

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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 _____

Sunscreen Consent:

I do_____ do not_____ consent to have our child carry and use sunscreen s/he has brought or the camp has supplied, which is approved by the FDA for over the counter use to avoid overexposure to the sun. Our child may be assisted by unlicensed camp staff if s/he requests.

Signature parent/guardian:

_____Date _____

Insect Repellent Consent:

I do_____ do not_____ consent to have our child carry and use insect repellent s/he has brought, which is no more than 35% DEET. Our child may be assisted by unlicensed camp staff if s/he requests.

Signature of parent/guardian:

_____ Date _____

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

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