CAMP MOVAL HEALTH FORM (2017)

Camper's Name:_____ Dates at Camp _____ Session_____

Home Phone: (____) _____ Date of Birth:_____ Age:_____ Gender:_____

Address:_____ City:_____ State:_____ Zip:_____

Camper lives with (check one):____Both Parents____Mother____Father____Other:_____
Parent/Guardian #1:_____ Parent/Guardian #2:_____
Work Phone: (____) _____ Work Phone: (____) _____
Emergency Contacts (to be used if we are unable to reach parents)
Name:_____ Relationship:_____ Phone(____) _____
Name:_____ Relationship:_____ Phone(____) _____
Name of Physician:_____ Phone(____) _____
Name of Dentist/Orthodontist_____ Phone(____) _____
Family Medical/Hospital Insurance: Carrier:_____ Policy or Group#_____
Dental Insurance Carrier:_____ Policy or Group#_____

************INCLUDE A COPY OF ALL INSURANCE CARDS WITH THIS FORM************

Description of any limitations or restrictions to camp activities:_____

_____

IMMUNIZATION HISTORY: Record the date (month & year) of basic immunizations and most recent booster doses **OR** attach a current copy of your child's school/clinic/physician immunization record.

Vaccines	basic Immunization	Booster
Diphtheria Pertussis (whooping cough) DPT* Tetanus **OR**	1 2 3	1 2
Tetanus TD* Diptheria **OR**		
Tetanus		
Oral Polio (Sabin)* TOPV	1 2 3	
Measles (hard measles, red measles, rubeola		
Mumps		
Rubella (German measles, 3-day measles)		
Other – specify		
Haemophilus influenza b (HIB)		
Hepatitis B		

*Date of most recent Tuberculin Test_____ Results_____ Date of last Tetanus Booster_____

IMPORTANT – <u>This section must be completed for attendance.</u>

THIS HEALTH FORM is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted above on this form.

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE: I hereby give permission to the medical personnel selected by the Camp Administration to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I herby give permission to the physician selected by the Camp Administration 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/LEGAL GUARDIAN
OR ADULT CAMPER/STAFF MEMBER:_____ **DATE**_____

WITNESS _____ **DATE**_____
I also understand and agree to abide by the restrictions placed on my camp activities.
SIGNATURE OF CAMPER/STAFFER_____ **DATE**_____

NAME OF CAMPER:_____ **Date of last Physical Exam:**_____

HEALTH HISTORY: **Camper's current weight:**_____

(Please answer Yes or No; if Yes give approximate dates.)

Allergies

____Frequent Ear Infections	____Hypertension	____Chicken Pox	____Poison Ivy/Oak	____Asthma
____Heart Defect/Disease	____Mononucleosis	____Measles	____Benadryl	____Insect Stings
____Epilepsy/Convulsions	____Diabetes	____German measles	____Penicillin	____Bee Stings
____Psychiatric Treatment	____Fainting/Dizzy Spells	____Mumps	____Other Drugs (specify):_____	
____Bleeding/Clotting Disorders	____Sleep Disorders	____Hay Fever	____Other (specify):_____	

Other Diseases OR Details of Above:_____

Food Allergies/Dietary Modifications:_____

Operations, Major Injuries or Hospitalization (dates)_____

Recommendations & Restrictions while at camp_____

Items your child may need help with while at camp: Fear of Dark____ Sleepwalking____ Bedwetting____ Other:_____

Any additional information about the participant's behavior, special needs, disabilities (physical, mental, learning, developmental), or physical, emotional, or mental health about which the camp should be aware. Include recent trauma or life changes.

For Females: Has she menstruated?_____ If not, has she been told about it?_____ If she has started, is her menstrual history normal?_____ Special Considerations:_____

MEDICATION: List all medications camper has taken in the past six months and all medications that will accompany him/her to camp (include over the counter medications and vitamins). Use additional form if necessary. ***Please bring all medications in original packaging including name and how to be given.***

Name of Medication	Date Started	Reason for Taking	When it is Given	Amount of Dose	How it is Given
			Breakfast Lunch Dinner Other		
			Breakfast Lunch Dinner Other		
			Breakfast Lunch Dinner Other		

The following non-prescription medications may be stocked in the camp health center and used on an ***as needed basis*** to illness or injury. Please cross out ***those that cannot be given***.

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medication
Diphenhydramine Antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

Any other information to ensure that your camper can have the best outdoor experience_____

CAMP MOVAL DOCTOR FORM Dates will attend camp: from _____to_____

To Parent(s)/Guardian(s): Complete this section *and give* ***this form (FORM 2)*** *and* ***a copy of your completed CAMPER HEALTH HISTORY FORM*** *to your child's health-care provider for review.*

Camper Name: _____

□ Male □ Female Birth Date ____/____/____ Age on arrival at camp _____

Camper home address: _____

Custodial parent(s)/guardian(s) phone: (_____)_____ (_____)_____

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Medical personnel: Cross out those items the camper should not be given.***

Acetaminophen (Tylenol)	Ibuprofen (Advil, Motrin)	Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)	Chlorpheneramine maleate	Guaifenesin
Dextromethorphan	Diphenhydramine (Benadryl)	Generic cough drops
Chloraseptic (Sore throat spray)	Lice shampoo (Nix or Elimite)	Calamine lotion
Bismuth subsalicylate (Pepto-Bismol)	Laxatives for constipation (Ex-Lax)	Hydrocortisone 1% cream
Topical antibiotic cream	Calamine lotion	Aloe

Physical exam done today: □ Yes □No (**If "No," date of last physical**: _____/_____/_____)

Weight: _____ lbs Height: _____ft_____in Blood Pressure_____/_____

ACA accreditation standards specify physical exam within last 24 months.

Allergies: □ No Known Allergies

□ To foods ***(list):***

□ To medications: ***(list):***

□ To the environment ***(insect stings, hay fever, etc.– list):***

□ Other allergies: ***(list):***

Describe previous reactions:

Diet, Nutrition: □ Eats a regular diet. □ Has a medically prescribed meal plan or dietary restrictions:***(describe below)***

The camper is undergoing treatment at this time for the following conditions: ***(describe below)*** □ None.

Medication: □ No daily medications. □ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe on Medication Form).***

Other treatments/therapies to be continued at camp: ***(describe below)*** □ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? □ No □ Yes

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): _____ Signature: _____

Office Address_____

Telephone: (_____)_____ Date:_____

MEDICATION SHEET

Name of Camper:_____ Camper's Height:_____

Camper's Weight:_____

Source of Information: ☐ Camper ☐ Medication Bottles or Packets
☐ Medication Administration List (attach copy if possible)
☐ Parent\Guardian\Caretaker\RN

Please list all medications, including topical and as needed PRNs.

	Medication Name	Strength	Dosage	Time
Currently Taking ☐ Yes ☐ No				
Currently Taking ☐ Yes ☐ No				
Currently Taking ☐ Yes ☐ No				
Currently Taking ☐ Yes ☐ No				
Currently Taking ☐ Yes ☐ No				
Currently Taking ☐ Yes ☐ No				
Currently Taking ☐ Yes ☐ No				
Currently Taking ☐ Yes ☐ No				
Currently Taking ☐ Yes ☐ No				
Currently Taking ☐ Yes ☐ No				