

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	1	1
Pertussis (whooping cough) DPT*	2	2
Tetanus	3	
OR		
Tetanus TD*		
Diphtheria		
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 – This section must be completed for attendance.

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 hereby 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)	Chlorpheniramine 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: _____

