CAMP MOVAL HEALTH FORM 2019

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:_____
Best Phone: (____)_____Best 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************

Immunization History: Provide the month and year for each immunization. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria,tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster (dT) or (TdaP)						
Mumps, Measles, Rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken Pox) Had Chicken Pox☐ Date:						
Meningococcal meningitis						

Tuberculosis (TB) Test	Date:	☐Negative ☐Positive

THIS HEALTH FORM is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

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:**_____

Health History Check "Yes" or "No" for each statement. Explain "Yes" answers below.

1. Ever been hospitalized? ☐ Yes ☐ No
2. Ever had surgery? ☐ Yes ☐ No
3. Have recurrent/chronic illnesses? ☐ Yes ☐ No
4. Had a recent infectious disease? ☐ Yes ☐ No
5. Had a recent injury? ☐ Yes ☐ No
6. Asthma/wheezing/shortness of breath ☐ Yes ☐ No
7. Heart disease/defect ☐ Yes ☐ No
8. Frequent ear infection ☐ Yes ☐ No
9. Bleeding/clotting disorders ☐ Yes ☐ No
10. High blood pressure ☐ Yes ☐ No
11. Diabetes ☐ Yes ☐ No
12. Seizures ☐ Yes ☐ No
13. Headaches ☐ Yes ☐ No
14. Wears glasses, contacts or eyewear ☐ Yes ☐ No
15. Fainting or dizziness ☐ Yes ☐ No
16. Passed out/had chest pain during exercise ☐ Yes ☐ No
17. Mononucleosis ☐ Yes ☐ No
18. Back/joint problems ☐ Yes ☐ No
19. Problems with diarrhea/constipation ☐ Yes ☐ No
20. Skin problems ☐ Yes ☐ No

Mental/Emotional/Social Health

21. ADD/ADHD ☐ Yes ☐ No
22. Anxiety/Depression ☐ Yes ☐ No
23. Bipolar ☐ Yes ☐ No
24. OCD ☐ Yes ☐ No
25. Eating Disorder ☐ Yes ☐ No
26. Sleepwalking/falling asleep ☐ Yes ☐ No
27. Bedwetting ☐ Yes ☐ No
28. Fear of storms ☐ Yes ☐ No
29. Fear of the dark ☐ Yes ☐ No
30. Emotional/Behavioral difficulties ☐ Yes ☐ No
31. Other mental health diagnosis ☐ Yes ☐ No
32. Learning disabilities ☐ Yes ☐ No

Explain any Yes answered questions: _____

_____

Allergies: ☐ No Known Allergies ☐ Food ☐ Medication ☐ Insects ☐ Environment ☐ Other _____

Please specify each allergy and reaction: _____

Diet/Nutrition: ☐ Regular Diet ☐ Diabetic ☐ Vegetarian ☐ Lactose Intolerant ☐ Gluten Free ☐ Other _____

Please Explain: _____

Restrictions: ☐ Camper Can Participate in all Programs ☐ Camper Has Restrictions (List) _____

_____

Females: Has she menstruated? ☐ Yes ☐ No If not, has she been told about it? ☐ Yes ☐ No Are there any problems we need to be aware of? _____

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		

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)
- Diphenhydramine Antihistamine (Benadryl)
- Sore throat spray
- Lidocaine (topical for sunburns/stings)
- Lice shampoo or cream (Nix or Elimite)
- Calamine lotion
- Laxatives for constipation (Ex-Lax)
- Tums
- Ibuprofen (Advil, Motrin)
- Guaifenesin cough syrup (Robitussin)
- Dextromethorphan cough syrup (Robitussin DM)
- Generic cough drops/throat drops
- Antibiotic cream
- Aloe
- Hydrocortisone (topical)
- Bismuth subsalicylate for diarrhea (Pepto-Bismol)
- Gatorade/Pedialyte

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)*** *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: Check those items the camper can be given.***

- □ Acetaminophen (Tylenol)
- □ Phenylephrine decongestant (Sudafed PE)
- □ Diphenhydramine Antihistamine (Benadryl)
- □ Sore throat spray
- □ Lidocaine (topical for sunburns/stings)
- □ Lice shampoo or cream (Nix or Elimite)
- □ Calamine lotion
- □ Laxatives for constipation (Ex-Lax)
- □ Tums
- □ Ibuprofen (Advil, Motrin)
- □ Guaifenesin cough syrup (Robitussin)
- □ Dextromethorphan cough syrup (Robitussin DM)
- □ Generic cough drops/throat drops
- □ Antibiotic cream
- □ Aloe
- □ Hydrocortisone (topical)
- □ Bismuth subsalicylate for diarrhea (Pepto-Bismol)
- □ Gatorade/Pedialyte

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 12 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:_____

Camper Name: ______________________________ Date Of Birth: ____________________

Allergies: ____

Medication Name	Date Started	Reason for Taking	When It Is Given	Dosage	How It Is Given
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:		
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			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other:		