

## 2017 Health History and Enrollment for Sam Davis Youth Camp for Youth and Adults

- Complete this form in ink answering all questions. Please print legibly
  - **The parent/guardian and camper both must sign this form.**
  - Mail to SDYC/SCV, P.O. Box 59 , Columbia, TN 38402
  - No one will be allowed to attend a Sam Davis Youth Camp without this completed form received at least 2 weeks before Camp
- USE ADDITIONAL PAPER FOR ANSWERS IF NECESSARY

The information on this form is gathered to assist Sam Davis Youth Camp in identifying appropriate care. Health history must be filled out annually by parents/guardians of minors or by adults themselves who serve as camp volunteer, counselor, staff or employee. Attach written documentation verifying health examination within two years from approved licensed medical personnel or have the Health Examination Portion completed and signed by same.

Dates of Camp Attendance VA 18-23 JUNE \_\_\_\_\_; TX 9-14 JULY \_\_\_\_\_

Please check appropriate box:    Youth Member(age 12-18)       Volunteer/Counselor       Staff/Employee  
   Gender:  M       F                                   Junior Counselor (19-21)

Participant's Full Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Age during Camp \_\_\_\_\_

Address \_\_\_\_\_  
                                 Street Address                                  City                                  State                                  Zip

Custodial Parent or Guardian \_\_\_\_\_

Home Address \_\_\_\_\_ Phone(    ) \_\_\_\_\_  
                                 Street Address                                  City                                  State                                  Zip

Parent/Family e-mail \_\_\_\_\_ Mobile(    ) \_\_\_\_\_

Business \_\_\_\_\_ Phone(    ) \_\_\_\_\_  
                                 Name of Company                                  Street Address                                  City                                  State                                  Zip

Second Parent or Guardian \_\_\_\_\_

Home Address \_\_\_\_\_ Phone(    ) \_\_\_\_\_  
                                 Street Address                                  City                                  State                                  Zip

Parent/Family e-mail \_\_\_\_\_ Mobile(    ) \_\_\_\_\_

Business \_\_\_\_\_ Phone(    ) \_\_\_\_\_  
                                 Name of Company                                  Street Address                                  City                                  State                                  Zip

If Parent(s) or Guardian not available in an emergency, notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone(    ) \_\_\_\_\_  
                                 Street Address                                  City                                  State                                  Zip                                  Mobile(    ) \_\_\_\_\_

**Insurance Information**

Is the member (camper) covered by family health/medical/hospital insurance?  Yes  No

Health Insurance Carrier \_\_\_\_\_ Group/Policy No. \_\_\_\_\_

Health Insurance Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Street Address City State Zip

Name of Insured \_\_\_\_\_ Relationship to Member (camper) \_\_\_\_\_

**Physician/Dentist Information**

Physician's Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Street Address City State Zip

Dentist's Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Street Address City State Zip

**Allergies/Dietary Restrictions**

List all known Allergies to medication, food, other (including insect stings, hay fever, penicillin, animal dander, plant allergies, etc.)

Any medical or religious meal plan or dietary restriction:  Yes  No Explain: \_\_\_\_\_

**Immunizations:** (must be completed or attach Immunization Record)

Date of last Tetanus shot \_\_\_\_\_

Which of the following has the participant had?

	Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Measles	DTP		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Chicken Pox	TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German Measles	Tetanus		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Polio		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	MMR		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Measles		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Mumps		_____	_____	_____	_____	_____	_____
	Or Rubella		_____	_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B		_____	_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (Chicken Pox)		_____	_____	_____	_____	_____	_____

List approximate date if participant has had or has been exposed to:

Chicken Pox \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Measles \_\_\_\_\_

If immunizations are not up-to-date, please explain: \_\_\_\_\_

My child has not had any immunizations due to parental religious beliefs and/or other beliefs  Yes  No

**Medications**

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last entire time at camp. All prescription medications must be in original bottle, identifying prescribing physician (if a prescription drug), showing name of medication, dosage, and frequency of administration.

This person takes medications as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific Time \_\_\_\_\_

Reason \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific Time \_\_\_\_\_

Reason \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific Time \_\_\_\_\_

Reason \_\_\_\_\_

This person takes NO medications on a routine basis.

Sam Davis Youth Camp is hereby granted permission to administer the following over-the-counter medications if the designated camp medical personnel deems it necessary Dosages will be administered to directions on the bottle unless a physician directs otherwise.

- Headache.....Tylenol/Ibuprophen/Aleve..... Yes  No
- Bites/Rashes.....Antihistimine/(Benadryl/Claritin)..... Yes  No
- Upset Stomach.....Pepto Bismol/Tums/Rolaid..... Yes  No
- Diarrhea.....Immodium AD..... Yes  No
- Menstrual Cramps.....Ibuprophen or Aleve..... Yes  No
- Poison Ivy.....Calamine Lotion or CortAid..... Yes  No
- Ear Infection from Swimming.....Swim Ear-Rx..... Yes  No
- Coughing.....Robitussin Cough Syrup..... Yes  No

**General Health** Height \_\_\_\_\_ Weight \_\_\_\_\_

(Explain "yes" answers below)

Has/does the participant:

- |   |   |
|---|---|
| 1. Had any recent injury, illness or infectious diseases, Measles, mumps, mononucleosis? <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Have hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No                                 |
| 2. Have a chronic or recurring illness or condition ear infections, heart condition? <input type="checkbox"/> Yes <input type="checkbox"/> No     | 8. Have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No                                    |
| 3. Had any loss of consciousness, convulsion, Or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No                             | 9. Have epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No                                  |
| 4. Have any medically prescribed meal plan or Dietary restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No                      | 10. Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No                                 |
| 5. Have any bleeding or clotting? <input type="checkbox"/> Yes <input type="checkbox"/> No  | 11. Had chicken pox? <input type="checkbox"/> Yes <input type="checkbox"/> No                               |
| 6. Have hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No  | 12. If female, have an abnormal menstrual history? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   | 13. Wear glasses, contacts or protective eye wear? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   | 14. Currently under physician's care? <input type="checkbox"/> Yes <input type="checkbox"/> No              |

Explain any "yes" answers, noting the number of the question. \_\_\_\_\_

Check below if participant is subject to:

- \_\_\_\_ Frequent Sore Throats
- \_\_\_\_ Headaches
- \_\_\_\_ Fainting
- \_\_\_\_ Sleep Walking
- \_\_\_\_ Sinusitis
- \_\_\_\_ Frequent Colds
- \_\_\_\_ Convulsions
- \_\_\_\_ Kidney Trouble
- Other – Specify \_\_\_\_\_

- \_\_\_\_ Athlete's Foot
- \_\_\_\_ Diarrhea
- \_\_\_\_ Epileptic Seizures
- \_\_\_\_ Constipation
- \_\_\_\_ Heart Trouble
- \_\_\_\_ Bronchitis Cramps
- \_\_\_\_ Ear Infections
- \_\_\_\_ Home Sickness
- \_\_\_\_ Bed Wetting

**Mental, Emotional and Psychological Health**

Has/does the participant:

- 1. Have an emotional health concern that will impact Camp participation? ..... Yes  No
- 2. Have a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder? ..... Yes  No

- 3. Have a significant life event that continues to affect the camper's life/health?..... Yes  No
- 4. Use an individualized learning plan at school?..... Yes  No
- 5. Diagnosed or treated for Attention Deficit Disorder (ADD)..... Yes  No

**Information about participant's physical, emotional, or mental health behavior, including sexual abuse, depression or suicide, of which the camp should be aware:**

---



---



---

**Does the Participant have a Criminal/Juvenile Record or serious school disciplinary record?  Yes  No**  
If yes, please explain \_\_\_\_\_

---

**Health Examination by Licensed Medical Physician, Physicians Assistant or (in some states\*) Certified Nurse Practitioner**

\*Check with your state health department to determine if a certified nurse practitioner is considered "licensed medical personnel."

Date of examination: \_\_\_\_\_

I have examined the camp applicant and, in my opinion, he/she  is  is not able to participate in an active camp program.

The applicant is under the care of a physician for the following condition(s): \_\_\_\_\_

---

**Recommendations and Restrictions at Camp for Health Reasons**

Description of any limitation or restriction on camp activities: \_\_\_\_\_

---

Treatment to be continued at camp: \_\_\_\_\_

---

Signature of Licensed Medical Personnel \_\_\_\_\_ Title \_\_\_\_\_

Doctor's Office/Clinic \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address City State Zip

- It is understood that all Sam Davis Youth Camp members in attendance will abide by the rules of the lodge and camp. If any member does not, the privileges of participating in the activities will be taken away; or in the case of a serious violation, the member will be returned home.
- By signing this form, I verify my child (camper) is at least 12 years of age.

**This health history is complete and correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. False, misleading, deliberately incomplete answers or failure to disclose a serious or serious condition that affects the camper, counselors or others at the camp, is grounds to dismiss a camper or counselor from Camp. For Camper, picking up the dismissed camper is the responsibility of the parents/guardians.**

**Personal Release:** I hereby irrevocably grant to Sam Davis Youth Camp the right to use, publish or distribute my and/or my child's image, name, voice and/or likeness, in whole or in part, for the purposes of promotion, education or marketing use by Sam Davis Youth Camp. I waive the right to inspect, approve or be compensated for the use to which it may be applied. I release Sam Davis Youth Camp for myself, my heirs, and executors, from all claims, demands or liabilities that may arise regarding the use of my and/or my child's image, name, voice or likeness. I have read and understand this Personal Release.

**Emergency Authorization:** I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for me as a volunteer, counselor, staff or employee, or my child in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child (or myself) as named above, if my child needs treatment for illness or injury which requires that he/she be taken from the camp to seek medical treatment. I understand that I will be notified immediately by the camp director or designee.

I hereby agree (pursuant to 45 CFR 164.510(b) to the disclosure to camp representatives of the protected health information of the person herein described as necessary: (I) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (II) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

- I understand and agree to abide by the rules and restrictions placed on my camp activities \_\_\_\_\_  
Signature of Youth Member
- *If for religious reasons you cannot sign this form, contact the camp for a legal waiver, which must be signed for attendance.* •