For Camp Use

Year

Cabin

Name

CAMP HEALTH EXAMINATION FORM
FOR CHILDREN, YOUTH AND ADULTS

Developed by
American Camp Association
American Academy of Pediatrics

Pages 1-3 completed by parent or staff member,
Page 4 completed by physician

Please return by June 1st to

CAMP ANDROSCOGGIN
601 West Street
Harrison, NY 10528

Name_____ Birth date _____ Age at camp_____

Home address _____

Social security number of participant _____ Gender: ❑ Male ❑ Female

Custodial parent/guardian _____ Home Phone _____

Home address _____

Cell Phone _____ Business Phone _____

Summer Phone (if different from above) _____

Second parent or guardian _____ Home Phone _____

Address _____

Cell Phone _____ Business Phone _____

If not available in an emergency, notify:

Name _____ Cell Phone _____

Relationship _____ Home Phone _____

Address _____ Business Phone _____

Insurance Information
Is the participant covered by family medical/hospital insurance? ❑ Yes ❑ No

If so, indicate carrier or plan name _____ Group # _____
Photocopy of front and back of health insurance card must be attached to this form.

Important–This box must be completed for attendance

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting in loco parentis if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. 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.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above.

I agree to notify the camp if my child is exposed to any communicable disease during the three weeks prior to camp attendance. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or staff _____

Printed Name _____ Date_____

Health History

The following information must be filled in by the parent/guardian or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival at camp. Provide complete information so that the camp can be aware of your needs.

Allergies (list all known) **Describe reaction and management of the reaction.**

Medication allergies (list)

_____ _____

_____ _____

_____ _____

_____ _____

Food allergies (list)

_____ _____

_____ _____

_____ _____

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

_____ _____

_____ _____

_____ _____

Medications Being Taken

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, frequency of administration and the dosage.

❑ **This person takes NO medication on a routine basis.**

❑ **This person takes medications 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 taken during the school year that participant **does/may not** take during the summer: _____

_____

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary) or diet.

_____

_____

_____

General Questions (Explain "yes"answers below.)

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infectious disease?	❑	❑
2. Have a chronic or recurring illness/condition?	❑	❑
3. Ever been hospitalized?	❑	❑
4. Ever had surgery?	❑	❑
5. Have frequent headaches?	❑	❑
6. Ever had a head injury?	❑	❑
7. Ever been knocked unconscious?	❑	❑
8. Wear glasses, contacts or protective eye wear?	❑	❑
9. Ever had frequent ear infections?	❑	❑
10. Ever passed out during or after exercise?	❑	❑
11. Ever been dizzy during or after exercise?	❑	❑
12. Ever had seizures?	❑	❑
13. Ever had chest pain during or after exercise?	❑	❑
14. Ever had high blood pressure?	❑	❑
15. Ever been diagnosed with a heart murmur?	❑	❑
16. Ever had back problems?	❑	❑
17. Ever had problems with joints (e.g., knees, ankles)?	❑	❑
18. Have an orthodontic appliance being brought to camp?	❑	❑
19. Have any skin problems (e.g., itching, rash, acne)?	❑	❑
20. Have diabetes?	❑	❑
21. Have asthma?	❑	❑
22. Had mononucleosis in the past 12 months?	❑	❑
23. Had problems with diarrhea/constipation?	❑	❑
24. Have problems with sleepwalking?	❑	❑
25. If female, have an abnormal menstrual history?	❑	❑
26. Have a history of bed-wetting?	❑	❑
27. Ever had an eating disorder?	❑	❑
28. Ever had emotional difficulties for which professional help was sought?	❑	❑

Please explain any "yes" answers, noting the number(s) of the question(s) and provide any additional information about the participant's physical, emotional, or mental health about which the camp should be aware.

_____

_____

_____

_____

_____

Which of the following has the participant had?

- ❑ Measles
- ❑ Chicken pox
- ❑ German measles
- ❑ Mumps
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C

TB Mantoux Test

Date of last test _____

Result: ❑ Positive ❑ Negative

Please give all dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	____	____	____	____	____	____
TD (tetanus/diphtheria)	____	____	____	____	____	____
Tetanus	____	____	____	____	____	____
Polio	____	____	____	____	____	
MMR	____	____				
or Measles	____	____				
or Mumps	____	____				
or Rubella	____	____				
Haemophilus influenza B	____	____	____	____		
Hepatitis B	____	____	____			
Varicella (chicken pox)	____	____				

Physician may attach a computerized patient record.

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Health Care Recommendations to be Completed by Family Physician

I examined _____ on _____
(name) (date)

BP _____ Weight _____ Height _____

In my opinion, the above applicant ☐ **is** ☐ **is not** able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

_____

_____

_____

_____

Recommendations and Restrictions at Camp

Treatment to be continued at camp

_____

_____

Medications to be administered at camp (name, dosage, frequency)

_____

_____

Known allergies

_____

_____

Description of any limitation or restriction on camp activities

_____

_____

Additional information for health care staff at the camp

_____

_____

_____

Signature of licensed medical personnel _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

For camp use only

Screening Record

Date Screened _____ Time _____ am/pm

Meds Received _____

Updates/Additions to health history notes ☐ Yes ☐ No ☐ None Required

Current health needs identified _____

_____

Observational notes _____

_____

Screened by _____