

Health History, Examination and Authorization Form for Children, Youth and Adults Attending Camp Amnicon

The information on this form is gathered to assist us in identifying appropriate care.

This form, except for "Health Recommendations of Licensed Medical Personnel" is to be filled in by parents/guardians of minors or by adults themselves.

Name _____ Birth date _____ Gender _____ Age _____
Last First Middle initial

Social Security Number of Participant _____

Custodial Parent or Guardian (or Spouse) _____

Home Address _____ Phone _____
Street & Number City State Zip Area/Number

Business _____ Phone _____
Street & Number City State Zip Area/Number

Second Parent or Guardian or Emergency Contact _____

Home Address _____ Phone _____
Street & Number City State Zip Area/Number

Business _____ Phone _____
Street & Number City State Zip Area/Number

If not available in an emergency, notify
 Name _____ Relationship _____

Address _____ Phone _____
Street & Number City State Zip Area/Number

<p>Health History (Give approximate dates.)</p> <p>_____ Frequent Ear Infections _____ Heart Defect/disease _____ Convulsions _____ Diabetes _____ Bleeding/Clotting Disorders _____ Hypertension _____ Mononucleosis _____ Diarrhea/Constipation _____ Sleepwalking</p> <p>Diseases</p> <p>_____ Chicken Pox _____ Measles _____ German Measles _____ Mumps _____ Other _____</p> <p>Allergies (Dates not needed)</p> <p>_____ Hay Fever _____ Ivy Poisoning, etc. _____ Insect stings _____ Penicillin _____ Other drugs _____ _____ Asthma _____ Other (Specify) _____</p>

Operations or surgeries (include dates) _____

Serious injuries (include dates) _____

Chronic or recurring illness/medical condition, including emotional/psychiatric

Infectious Diseases _____

Current medications (send with instructions) _____

Dietary restrictions _____

Other _____

Name of dentist/orthodontist _____ Phone _____

Name of family physician _____ Phone _____

Do you carry family medical/hospital insurance? _____ Yes _____ No

If yes, indicate: Carrier _____ Policy or group # _____

Carrier address _____

Name of insured _____ Relationship to participant _____

Social Security Number of policy holder or insurance ID# _____

For Female Participant:

Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special consideration _____

Important-Signature Required For Attendance*

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has my permission to engage in all camp activities including those listed in the brochure, program information sheet and "Information for Campers/ parents" except as noted.

I hereby give permission to the camp to provide routine health care and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

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. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staff _____
 Printed Name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staff _____ Date _____

Immunization

History

Required immunizations must be determined locally.

Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria	1	1
Pertussis (Whooping Cough)	2	2
Tetanus or	3	
Tetanus Diphtheria or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given (most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant within the past two years. Date Examined _____

In my opinion, the above's condition _____ does _____ does not preclude his/her participation in an active camp program.

Height _____ Weight _____ Blood Pressure _____

The applicant is under the care of a physician/chiropractor/other health care provider (specify _____) for the following condition(s) _____

Current treatment (include current medications) _____

Explanation of any reported loss of consciousness, convulsion, concussion, recurring headaches, or head injury _____

Does applicant have epilepsy? yes no Does applicant have diabetes? yes no

Recommendations and Restrictions while at Camp

Any treatment to be continued at camp _____

Any medication to be administered at camp (specific dosages) _____

Any medically prescribed meal plan or dietary restrictions _____

Any allergies (food, drugs, plants, insects, etc.) _____

Activities to be encouraged _____

Activities to be limited; explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) _____

Additional Health Information _____

Licensed Medical Personnel Signature Required For Attendance

Licensed Physician's Signature _____

Address _____ Phone _____
Street and Number City State Zip Area/Number

Date of Form Completion _____ *By _____

Initial if completed by nurse or physician's assistant.