

Health History and Examination for **CAMP WEED 2010**

(Adapted Form FM 08N)

Developed based on information supplied by: The American Camping Association, Inc.,
The American Medical Association and The American Academy of Pediatrics

Mail Form To: Camp Weed Health Form
325 N. Market Street
Jacksonville, FL 32202

The information on this form is gathered to assist us in identifying appropriate care. Health history (pages 1-3) must be filled out by parents/guardians of minors or by adults themselves.

ALL PAGES TO BE FULLY COMPLETED.
Health exam (page 4) must have occurred within one year of camp session and MUST be completed by medical personnel annually.

Name _____ Birth Date _____ Age at camp _____
Last First Middle Initial

Home address _____
Street Address City State Zip Code

Social security number of participant (optional) _____ Gender Male Female

Custodial parent/guardian _____ Phone _____

Home Address _____
(If different from above) Street Address City State Zip Code

Business Address _____ Phone _____
Street Address City State Zip Code

Second parent/guardian _____

Home Address _____ Phone _____
Street Address City State Zip Code

Business Address _____ Phone _____
Street Address City State Zip Code

If not available in an emergency, notify: _____

Relationship _____ Phone _____

Address _____
Street Address City State Zip Code

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 Information – Please Read Carefully

1. All four pages of this medical form must be fully completed with **signatures** and **returned** to Camp Weed **one month** prior to the beginning of camp.
2. Camper must have had a **tetanus immunization within the previous 10 years**.
3. Camper must have had a **physical within previous 12 months** of camp dates. The last page must be **signed by a physician**, physician assistant, or nurse practitioner. If you are unable to secure an appointment before camp, you may substitute another physical exam report such as a sports or school physical. However, the substituted report must be signed by a physician, physician assistant, or nurse practitioner. This form must still be completed by the parent along with substituted report. We cannot use forms from previous years, please complete a new health form every year.
4. All **prescription medication** must be in the **original pharmacy container** labeled with the **child's name**, the **name of the drug**, and **instructions** for administration in a zip lock bag. It is illegal for our infirmary to dispense medication from improperly labeled containers.
5. Individuals with a **preexisting** medical condition or illness (especially a **contagious illness**) **cannot be admitted** and will be sent home as soon as possible at parental expense. Any registration payment made to the camp will not be refunded.

*** If all of these requirements are not met, the medical staff may refuse the camper admittance at registration.

Important – The following 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 purpose 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. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____

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/staffer _____ Date _____

General Questions (Explain "yes" answers below)

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

Please explain any "yes" answers, noting the number of the questions.

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
DTP		_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____
MMR		_____	_____			
or Measles		_____	_____			
or Mumps		_____	_____			
or Rubella		_____	_____			
Haemophilus influenza B		_____	_____	_____		
Hepatitis B		_____	_____	_____		
Varicella (chicken pox)		_____	_____			

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Health History

The following information must be filled in by the parent/guardian, or adult camper 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 in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES. List all know.

Medication allergies (list)

Describe reaction and management of the reaction.

_____	_____
_____	_____
_____	_____
_____	_____

Food allergies (list) – please contact the camp office if your camper is in need of a specific food regimen because of a medical condition. We want and need to have a clear understanding of the individual's dietary needs.

_____	_____
_____	_____
_____	_____
_____	_____

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs and vitamins) that are 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, the dosage, and the frequency of administration. **Please put all medications in one zip lock bag marked clearly with the campers name.**

This person takes **NO** medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____ Specific time taken each day _____
Reason for taking _____

Med #2 _____ Dosage _____ Specific time taken each day _____
Reason for taking _____

Med #3 _____ Dosage _____ Specific time 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: _____

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

- | | | |
|--|---|--|
| <input type="checkbox"/> Does not eat red meat | <input type="checkbox"/> Does not eat pork | <input type="checkbox"/> Does not eat eggs |
| <input type="checkbox"/> Does not eat poultry | <input type="checkbox"/> Does not eat seafood | <input type="checkbox"/> Does not eat dairy products |

Other (describe) _____

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

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____

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) _____

Any medically-prescribed meal plan or dietary restrictions _____

Known allergies _____

Description of any limitation or restriction on camp activities _____

Additional information for health care staff at Camp Weed _____

Signature of Licensed Medical Personnel (required) _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

For camp use only

Screening Record

Date screened _____ Time _____ am
pm

Meds received _____

Updates/additions to health history noted Yes No None required

Current health needs identified _____

Observation notes _____
