SESSION:

Return by Mail: Camp Weed Health Form
325 N. Market Street
Jacksonville, Fl 32202
OR Fax: 904-355-1934
OR Email: dioceseflyouth@gmail.com

Health History and Examination for CAMP WEED 2012

(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

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
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever had surgery?	☐	☐
4. Have frequent headaches?	☐	☐
5. Have frequent ear infections?	☐	☐
6. Ever been knocked unconscious?	☐	☐
7. Ever had a head injury?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever passed out during or after exercise?	☐	☐
10. Ever had seizures?	☐	☐
11. Ever had high blood pressure?	☐	☐
12. Ever been diagnosed with a heart murmur?	☐	☐
13. Have a heart disease/defect?	☐	☐
14. Ever had back problems?	☐	☐
15. Ever had problems with joints (e.g. knees, ankles)?	☐	☐
16. Have an orthodontic appliance being brought to camp?	☐	☐
17. Have diabetes?	☐	☐
18. Have asthma?	☐	☐
19. Had mononucleosis in the past 12 months?	☐	☐
20. Have problems with sleep walking?	☐	☐
21. Have a history bed-wetting?	☐	☐
22. Ever had an eating disorder?	☐	☐
23. If female, have an abnormal menstrual history?	☐	☐
24. Ever had emotional difficulties for which professional help was sought?	☐	☐

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

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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.

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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

☐ Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs
☐ Does not eat poultry ☐ Does not eat seafood ☐ 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

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____

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____

____

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____

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