

# MERRY MOUNT RIDING CAMP

## Health History and Examination Form For Campers

This information will not be used to determine camper or staff acceptance, but to assist us in identifying proper care. This form, except for the "Health Recommendations of Licensed Medical Personnel", to be completed by parents/guardians of minors or by adults themselves.

Name (first, m.i., last)	Birth date	Age at camp
Address	City	State Zip
Social Security number of camper	Gender:	Female Male
Custodial parent/guardian	Phone	
Home address	State	Zip
Work address	Phone	
Second parent/guardian/emergency contact	Phone	
Address	State	Zip
Work address	Phone	
If not available in an emergency, contact	Phone	
Relationship		
Address	State	Zip

### INSURANCE INFORMATION

Is the camper covered by family medical/hospital insurance?	Yes	No
Carrier or Plan Name	Group #	
Carrier address		
Name of insured	Relationship to camper	
Social Security No. of policyholder or insurance ID No.		

#### Permission to Provide Necessary Treatment and Emergency Care:

I do/do not permit the medical personnel selected by the camp director to order routine tests, x-rays, or treatments; to release records necessary for insurance purposes; and to provide or arrange necessary transportation to medical facilities. Routine treatments may include the administration of over-the-counter medications, such as Tylenol, Pepto Bismal, or Benadryl, in recommended dosages. In the event I cannot be reached in an emergency, I do/do not permit the physician selected by the camp director to administer and secure treatment, including hospitalization, for the person named above. This form may be photocopied for trips out of camp.

#### YOU MUST SIGN ONE OF THE TWO BOXES BELOW

I GRANT permission: \_\_\_\_\_ Date \_\_\_\_\_

I DO NOT GRANT permission: \_\_\_\_\_ Date \_\_\_\_\_

## HEALTH HISTORY

The following information must be filled in by the parent/guardian, or adult camper or staff member. The information will provide health care personnel with the necessary background to provide appropriate care. Please provide complete information so that the camp can be aware of your needs.

**ALLERGIES** List all known Describe reaction and treatment

### Medication Allergies

_____	_____
_____	_____
_____	_____

### Food Allergies

_____	_____
_____	_____
_____	_____

**Other Allergies** – include insect stings, hay fever, asthma, animal dander, etc.

_____	_____
_____	_____
_____	_____

## MEDICATIONS BEING TAKEN

List ALL medications being taken on a regular basis, including all over-the-counter and nonprescription drugs. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing doctor, name of medication, dosage, and frequency of dosage.

This person takes medications as follows:     This person takes NO medication on a routine basis:

Med #1	Dosage	Times
Reason for taking		
Med #2	Dosage	Times
Reason for taking		
Med #3	Dosage	Times
Reason for taking		

Identify any medications taken during the school year that camper does/may not take during the summer.

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**RESTRICTIONS** The following restrictions apply to this individual:

### Dietary

- Can not eat red meat                       Can not eat pork                       Can not eat eggs
- Can not eat poultry                       Can not eat seafood                       Can not eat dairy products
- Other (describe) \_\_\_\_\_

**Explain any restrictions to activity**

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**GENERAL QUESTIONS**

<b>Has the camper:</b>	<b>Y</b>	<b>N</b>		<b>Y</b>	<b>N</b>
Had any recent injury, illness, or infectious disease			Is an orthodontic appliance being brought to camp		
Have a chronic or recurring illness/condition			Ever been diagnosed with a heart murmur?		
Ever been hospitalized?			Ever had problem with joints (e.g., knees, ankles)?		
Ever had surgery?			Ever had back problems?		
Have frequent headaches?			Have any skin problems (e.g., itching, rash, acne)?		
Ever had a head injury?			Have diabetes/hypoglycemia?		
Ever been knocked unconscious?			Have asthma?		
Wear glasses, contacts, or protective eyewear?			Had mononucleosis in the last 12 months?		
Ever had frequent ear infections?			Had problems with diarrhea/constipation?		
Ever passed out during or after exercise?			Have problems with sleepwalking?		
Ever been dizzy during or after exercise?			If female, have an abnormal menstrual history?		
Ever had seizures?			Have a history of bed-wetting?		
Ever had chest pain during or after exercise?			Ever had an eating disorder?		
Ever had high blood pressure?			Ever had emotional difficulties for which professional help was needed?		

**Please explain any "yes" answers**

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Please give all dates of immunization for:

Vaccine	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						
Negative						
Hepatitis B						
Varicella (chicken pox)						
BCG						

Which of the following has the camper had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis

TB Mantoux Test

Date of last test:

Result:  Positive

Any additional information about the camper's behavior or physical/emotional/mental health?

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Name of family physician	Phone
Address	
Name of family dentist/orthodontist	Phone
Address	

Parent/Guardian Authorization: This health history is correct and complete as far as I know and the signed person herein described has permission to participate in all camp activities except as noted.

Signed \_\_\_\_\_

Printed \_\_\_\_\_

Date \_\_\_\_\_

**Health Care recommendations by Licensed Medical Personnel**

I have examined the above camp participant \_\_\_\_\_ Date of last examination \_\_\_\_\_

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above camper \_\_\_\_\_ is \_\_\_\_\_ is not able to participate in an active camp program.

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

\_\_\_\_\_  
\_\_\_\_\_

Current treatment at the time of this report includes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 limitations or restrictions on camp activities: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Additional information for camp staff: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Signature of Licensed Medical Personnel** \_\_\_\_\_

Name printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_