

Camp Name:
Mailing Address:
Phone:

Camp Year:

Fax:

Summer Camp Address:
Phone #:

(From _____ to _____)

REQUIRED MEDICAL HISTORY
(Parent or Legal Guardian to Complete)

Please Check One: () Returning Camper () New Camper () Returning Staff () New Staff
Session: _____

Name _____ **Date of Birth:** _____
Address _____ **Phone#:** _____

Emergency Notification:

With whom does child reside and what is / are his / her relationship(s) with the child? _____

Parent 1 Name _____ Phone: Home _____ Work _____ Cell _____

Parent 2 Name _____ Phone: Home _____ Work _____ Cell _____

Person to contact in an emergency if parents are unavailable:

Name: _____ Phone: Home _____ Work _____ Cell _____

Physician: _____ Phone _____

Dentist/Orthodontist: _____ Phone _____

Emergency Medical Information (check yes or no)

Yes ___ **No** ___ Allergy to a medicine, food, plant, animal, or insect

Yes ___ **No** ___ Do you have an epinephrine pen?

Yes ___ **No** ___ Any condition that requires special care, medication or diet

Yes ___ **No** ___ Asthma

Yes ___ **No** ___ Contact Lenses

Yes ___ **No** ___ Seizure Disorder

Yes ___ **No** ___ Diabetes

Yes ___ **No** ___ Heart Trouble

Yes ___ **No** ___ Bleeding Disorder

Yes ___ **No** ___ Dentures

Yes ___ **No** ___ Bonded Teeth

Explain any of the above: _____

Medical History (check yes or no)

	Yes	No	Date	Details
Serious illness	_____	_____	_____	_____
Serious injury	_____	_____	_____	_____

Does your child have frequent: (circle yes or no)

Y / N Eye Infections **Y / N** Respiratory Infections

Y / N Ear Infections **Y / N** Urinary Tract Infections

Y / N Throat Infections **Y / N** Vaginal Infections

Does your child have: (circle yes or no)

Y / N Heart Murmur **Y / N** Menstrual Problems

Y / N Rheumatic Fever **Y / N** Hernia

Y / N Stomach/Intestinal Problems **Y / N** Back or Joint Pains

Explain any of the above: _____

Has this person had Chicken Pox? () Yes () No If yes, when? Date _____

Has this person had Mumps? () Yes () No If yes, when? Date _____

Has this person been exposed to a contagious disease within the past three weeks? _____

Has this person had lice in the past six months? _____

If applicable, has this person started menstruation? () Yes () No Has she been told about menstruation? () Yes () No

Does this person take any medication on a regular basis? Yes _____ No _____

Explain: _____

Family Insurance Information: Please send a copy of both the front and back of all Health Insurance and Prescription Cards so they can be submitted at time of service to save you money.

Policy Holder _____ Carrier _____

Policy Number _____ Address _____

Does this policy include dental coverage? Yes _____ No _____

To the best of my knowledge, the above information is correct. I give my child permission to participate in all camp activities and trips.

In the event of accident or illness, I authorize the Camp to institute and obtain medical care.

**** In the event of a communicable disease outbreak, I understand this person will be excluded from camp if not fully immunized.**

DATE _____ **SIGNATURE (parent or legal guardian)** _____

MEDICAL EVALUATION

(To be completed by physician)

Name _____ Date of Birth _____ has had a complete history and physical exam on _____
Month/Day/Year Month/Day/Year

Screening / Test Results

Height:	BMI:	Vision/Type of Screening
Weight:	<input type="checkbox"/> Normal	With Glasses R 20 / L 20 /
Blood Pressure:	<input type="checkbox"/> Abnormal	With out Glasses R 20 / L 20 /
Pulse:	Min:	
HCT/Hgb:	Slight:	Auditory /Type of Screening
Urinalysis:	Mod:	Right Pass / Fail
Gross Dental:	Marked:	Left Pass / Fail
Lead (Date/Result):	<input type="checkbox"/> Referral to:	

TB: In high-risk group? <input type="checkbox"/> yes <input type="checkbox"/> no		
TB & other Test Results: (Sickle Cell, etc.)		
Test	Date	Result

Disease Assessment

Yes	No		Date of Onset
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Exercise Induced <input type="checkbox"/> Unclassified
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/> Type I <input type="checkbox"/> Type II
<input type="checkbox"/>	<input type="checkbox"/>	Anaphylactic Reaction	<input type="checkbox"/> Food <input type="checkbox"/> Insect <input type="checkbox"/> Latex <input type="checkbox"/> Other: Explain
<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	Type:
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	If yes, when?
<input type="checkbox"/>	<input type="checkbox"/>	Mumps	If yes, when?
<input type="checkbox"/>	<input type="checkbox"/>	Other: Please Specify	

Immunization History

(Please provide month, day and year of immunization)

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DPT / Hib						
DTaP						
DT / Td						
OPV						
IPV						
MMR						
HiB						
Hep B						
Hep A						
Varicella						
TDap						
PCV						
HPV						
MCV						
Influenza						

Prescription Medication: Please complete with patient's current regimen for both scheduled and PRN medications including heparin flushes for central lines; please use additional paper if needed.

DRUG	ROUTE	DOSAGE	FREQUENCY	COMMENTS

Individualized Orders: The following Standard “Over the Counter / PRN Medications “ are available in the Health Center to be administered if needed per the family physician’s instructions.

***** THIS SECTION MUST BE COMPLETED *****

Drug Name (Generic equivalents may be used)	Dosage	Route	Indications	Healthcare Provider Permission	Comments
Diphenhydramine	As per pkg by wt. & age	PO	Allergies or Allergic Reactions	Yes / No	
Burn Gel	Apply to minor burns	Topically	Minor Burns	Yes / No	
Stool Softner	As per pkg by wt. & age	PO	No BM x 3 Days	Yes / No	
Acetaminophen	As per pkg by wt. & age	PO	Temp. \geq 100°F or Pain	Yes / No	
Ibuprofen	As per pkg by wt. & age	PO	Temp. \geq 100°F or Pain	Yes / No	
Hydrocortisone	Apply to effected area 3x/day	Topically	Itch	Yes / No	
Cough Drops	As per pkg by wt. & age	PO	Cough or Sore Throat	Yes / No	
Antacid	As per pkg by wt. & age	PO	Upset Stomach	Yes / No	
Antibiotic Oint.	Apply to effected area 3x/day	Topical	Scrapes or Cuts	Yes / No	

This form is not exhaustive or restrictive. It is meant by the Putnam County Health Department only as a guide.

Please note, *if the provider has not circled yes, it means no.* Following the above without the provider’s explicit direction is practicing medicine without a license.

Emergency Medications:

Does this person require: Epi-pen: yes no PRN Inhaler: yes no
 This person has permission to carry: Epi-pen: yes no PRN Inhaler: yes no
 (Note: ability to carry implies ability to self administer)

Additional Orders: As deemed necessary by health care provider to be implemented by an R.N. (i.e. peak flows, blood draws/lab work, dressing changes, cast care, feeds via GT, etc.):

Limitations on Activities: Swimming _____ Diving _____ Hiking _____ Athletics _____ Other: _____

Explain above: _____

HIPPA Privacy Statement: Permission to Release Confidential Health Information

I give _____ permission to release confidential health information to
Name of Medical Practice
 _____ regarding this person _____
Name of Camp Name of Camper or staff member

Date: _____ Parents/Guardian Signature: _____

I certify that I have on this date examined the above named camper and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this camper to participate in physically strenuous activities.

Signature of Physician _____ Date of Examination _____

Please Print: Physician’s Name _____ License# _____

Address _____ Phone# _____

Parents Signature: _____ Date: _____

Update to Health Form

Please note any changes to medication since the "Required Medical History" forms were submitted. Be sure to note changes in dose (strength or number of mgs) or the number of times per day that a medicine is taken even of medicines that were on the original health form.

Any changes must be signed for by the prescriber!

Medication Name	Dose	Frequency	Route

Remember camper can not receive vitamins, supplements, herbal preparations or homeopathic remedies without a prescription.

Note any changes in the campers physical or medical condition since the original health form was submitted.

Medical Change or Condition:

Date of Onset: _____ Condition; _____
Date of Onset: _____ Condition; _____
Date of Onset: _____ Condition; _____
Date of Onset: _____ Condition; _____
Date of Onset: _____ Condition; _____

Consent of Physician:

Signature of Physician _____ Date of Examination _____

Please Print: Physician's Name _____ License# _____

Address _____ Phone# _____

Consent of Parent/Guardian:

Parents Signature: _____ Date: _____