

# CAMP CHAMPIONS 2010

## HEALTH HISTORY AND EXAMINATION FORM FOR COUNSELORS/SUMMER EMPLOYEES

*This side for COUNSELOR/SUMMER EMPLOYEE to complete*

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Parent or Guardian \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_

Business \_\_\_\_\_ Phone \_\_\_\_\_

Second Parent, Guardian or Emergency Contact \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_

Business \_\_\_\_\_ Phone \_\_\_\_\_

If not available in an emergency, please notify:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

HEALTH HISTORY: (check and give approximate dates)					
Frequent Ear Infections	_____	Mononucleosis	_____		
Heart Defect/Disease	_____	<b><u>Diseases</u></b>		<b><u>Allergies</u></b>	
Convulsions	_____	Chicken Pox	_____	Hay Fever	_____
Diabetes	_____	Measles	_____	Ivy Poisonings	_____
Bleeding/Clotting Disorders	_____	German Measles	_____	Penicillin	_____
Hypertension	_____	Mumps	_____	Insect stings	_____
Asthma	_____	Other	_____	Other Drugs	_____
Nocturnal enuresis	_____			Other	_____

Have you ever required any counseling/therapy? If yes, please explain \_\_\_\_\_

\_\_\_\_\_ had operations or serious injury? (dates) \_\_\_\_\_

Do you have disabilities or recurring illnesses: \_\_\_\_\_

Activities to be encouraged or limited by physician's advice: \_\_\_\_\_

Dietary modifications: \_\_\_\_\_

Current medication (send with instructions): \_\_\_\_\_

Name of dentist/orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of family physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

Do you carry family medical/hospital insurance? \_\_\_\_\_ Carrier: \_\_\_\_\_

Policy or Group #: \_\_\_\_\_

Suggestions or health-related information for Camp Champions staff: \_\_\_\_\_

This health history is correct so far as I know, and the person listed above has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the camp: 1. To provide ongoing health care; and, 2. To select medical personnel and to order X-rays or routine tests or treatment for the person listed above. Furthermore, in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above. This form may be photocopied for use out of camp.

SIGNATURE \_\_\_\_\_ Date: \_\_\_\_\_ (over)

## IMMUNIZATION HISTORY

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 <input type="checkbox"/> Pertussis (Whooping Cough) DPT Tetanus or	1 2 3	1 2
Tetanus Diphtheria TD or		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Haemophilus influenza b (HIB)		
Other		Tuberculin test given _____ (most recent)

## HEALTH EXAMINATION BY A LICENSED PHYSICIAN

Date Examined: \_\_\_\_\_

I have examined the above camp applicant within the past *six months*.

Height \_\_\_\_\_

Weight \_\_\_\_\_

In my opinion, the above's condition

does preclude

Blood pressure \_\_\_\_\_

does not preclude his/her participation in an active camp program.

The applicant is under the care of a physician for the following condition(s): \_\_\_\_\_

Current treatment (include current medications): \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion, or concussion: \_\_\_\_\_

Does applicant have epilepsy? Yes  No

Does applicant have diabetes? Yes  No

## RECOMMENDATIONS & 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.): \_\_\_\_\_

## ADDITIONAL HEALTH INFORMATION

Licensed Physician's Signature \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

Street & Number

City

State

Zip

Date of Form Completion \_\_\_\_\_

By \_\_\_\_\_