

Health History and Examination Form

for children, youth and adults

As long as the information stays current, **this form is valid for 2 years.**
Space is provided for updates the second year.

Camp Chanco

PO Box 378

Surry, VA 23883

Phone: 757-294-3126 Fax: 757-294-0727

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The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. The first three pages are to be filled in by parents/guardians of minors or by adults themselves. The fourth page is the physical exam portion to be completed by a physician, physician's assistant, or nurse practitioner.

Name _____ Birth date _____ Age at camp _____

Last First Middle

Home address _____

Street City State Zip

Social security number of participant _____ Gender: Male Female

Custodial parent/guardian spouse _____ Relationship to participant _____

Preferred phone: (____) _____ cell home work Alternate phone: (____) _____

Home address _____

(if different from above) Street City State Zip

Second parent/guardian spouse _____ Relationship to participant _____

Preferred phone: (____) _____ cell home work Alternate phone: (____) _____

Home address _____

(if different from above) Street City State Zip

If not available in an emergency, notify:

Name _____ Relationship _____ Home Phone: (____) _____

Address _____ Work Phone: (____) _____

Street City State Zip Cell Phone: (____) _____

Insurance Information

Is the participant covered by medical/hospital insurance? yes no

If so, indicate carrier or plan name _____ Group number _____

Carrier phone numbers _____

Name of insured _____ Relationship to participant _____

Social security number of policy holder or insurance ID number _____

◆◆◆ **IMPORTANT—This section must be complete for attendance** ◆◆◆

- I consent and give permission for Camp Chanco's medical personnel and designated staff to administer authorized medication, first aid and/or emergency treatment to me and/or my child. In addition, I give permission and consent to Camp Chanco's medical personnel and/or staff to provide or arrange transportation for me and/or my child and to select and consent to health care providers evaluating, testing, treating and/or hospitalizing me and/or my child when in their opinion such services are needed. I also consent to the release of medical records and medical information in order to secure medical care and/or payment for medical services.
- This completed form may be photocopied for trips out of camp.

Signature of parent/guardian/adult camper or staffer _____

Please print your name here _____ Date Signed _____

Session

Year

Session

Year

First

Last

Name

(For camp use only)

Health History

Name _____

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 in health history should be provided to camp health personnel upon participant's arrival in camp. Please provide complete information so that the camp can be aware of any health concerns.

Allergies

- The participant has NO KNOW MEDICATION ALLERGIES**
- The participant has the following medication allergies** (please describe the reaction and the management of the reaction)

- The participant has NO KNOW FOOD ALLERGIES**
- The participant has the following food allergies** (please describe the reaction and the management of the reaction)

Other Allergies: (please list—include hay fever, asthma, animal dander, and special sensitivities to insect stings, poison ivy, etc.)

Medications

- This person brought NO medication to take while at camp.**
- This person brought the following medication to take while at camp.**

Note: Please list all medications to be taken routinely and as needed, including prescription and over-the-counter. Keep all medication in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

Med #1 _____ Dosage _____ Frequency _____
Reason for taking _____

Med #2 _____ Dosage _____ Frequency _____
Reason for taking _____

Med #3 _____ Dosage _____ Frequency _____
Reason for taking _____

Med #4 _____ Dosage _____ Frequency _____
Reason for taking _____

Med #5 _____ Dosage _____ Frequency _____
Reason for taking _____

Med #6 _____ Dosage _____ Frequency _____
Reason for taking _____

Med #7 _____ Dosage _____ Frequency _____
Reason for taking _____

<i>(For camp use only)</i>				
1)	8:30a	1p	6:30 p	Bed
2)	8:30a	1p	6:30 p	Bed
3)	8:30a	1p	6:30 p	Bed
4)	8:30a	1p	6:30 p	Bed
5)	8:30a	1p	6:30 p	Bed
6)	8:30a	1p	6:30 p	Bed
7)	8:30a	1p	6:30 p	Bed

Restrictions

- There are NO restrictions for this individual.**
- The following restrictions apply to this individual:**

Restrictions on **Activity**. _____

Restrictions on **Diet**. *(list foods cannot have and why)* _____

If any restrictions, this section must be signed by participant.

Signature of Camper/staffer: _____ Date signed _____

General Question: (Please complete immediately prior to coming to camp and explain "yes" answers in space provided)

Has/does the participant:	Yes No			Yes No	
1. Had recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever had problems with joints?	<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 been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have any skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	20. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been dizzy or passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	21. Had any fractures?	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	22. Have problems with sleep walking?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	23. If female, have an abnormal menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever been diagnosed with heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	25. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>			
14. Ever had back problems	<input type="checkbox"/>	<input type="checkbox"/>			

Explanations to any "yes" answers above, noting the number of the questions:

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

Which of the following illnesses has the participant had? <table border="0" style="width: 100%;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Measles</td> <td></td> <td></td> </tr> <tr> <td>Chicken Pox</td> <td></td> <td></td> </tr> <tr> <td>German Measles</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Mumps</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Hepatitis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	Measles			Chicken Pox			German Measles	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<p>Immunizations</p> <p>(Note: Due to nature of camp, tetanus immunization within last 5 years is preferred) Please give complete date of most recent tetanus Immunization.</p> <p>DTP (diphtheria/tetanus/pertussis) _____</p> <p>Tetanus-diphtheria (Td) _____</p> <p>Tetanus _____</p>	Please also provide the following info, giving date of last injection/ingestion. Has camper had the following series? Polio <input type="checkbox"/> yes <input type="checkbox"/> no Date _____ Haemophilus influenza B? <input type="checkbox"/> yes <input type="checkbox"/> no Date _____ Hepatitis B? <input type="checkbox"/> yes <input type="checkbox"/> no Date _____ Varicella (chicken pox)? <input type="checkbox"/> yes <input type="checkbox"/> no Date _____ BCG? <input type="checkbox"/> yes <input type="checkbox"/> no Date _____ MMR? <input type="checkbox"/> yes <input type="checkbox"/> no Date _____
	Yes	No																								
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Name of family physician _____ Phone (____) _____

Address _____

Name of dentist/orthodontist _____ Phone (____) _____

Address _____

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

Signed _____ Printed Name _____ Date _____

Health Care Recommendations by Licensed Medical Personnel (MD, PA, or NP)

Name of camp participant _____

Date of Examination ____/____/____ (must be within 2 years of camp attendance) Date form completed ____/____/____

BP _____/_____ Weight _____ lbs. Height _____ ft. _____ in.

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

Known Allergies (essential information):

Medication allergies: _____

Food and other allergies: _____

Medications to be administered at camp (name, dosage, frequency):

Pertinent abnormal physical findings: _____

- In my opinion, the above person is able to fully participate in an active camp program.
- In my opinion, the above person is not able to fully participate in an active camp program.

Limitations and/or restrictions placed on activities:

Treatment to be continued at camp:

Medically-prescribed meal plan or dietary restrictions::

Additional information for camp health care staff:

Signature of Licensed Medical Personnel	Date
Printed Name	
Title	
Address	
(_____) _____	
Phone	