

Camper Medical Form

SUMMER 2008

The information on this form is not part of the camper acceptance process but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians. Page 4 to be completed by Physician.

Mail this form to the address below by 5/1/08
MOUNT TOM DAY CAMP
48 Mount Tom Road
New Rochelle, NY 10805
Fax #: 914 576 3270

Gender: Male Female

Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address _____
Street address City State Zip

Custodial parent/guardian _____ Cell Phone _____

Home address _____ Home Phone _____
(if different from above) Street address City State Zip

Business address _____ Bus Phone _____
Street address City State Zip

Second parent / guardian / emergency contact _____ Cell Phone _____
(please circle one)

Address _____ Home Phone _____
Street address City State Zip

Business address _____ Bus Phone _____
Street address City State Zip

If above not available in an emergency, notify:

Name _____ Cell Phone _____

Relationship _____ Day Phone _____

Address _____
Street address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____ Tele # _____

ALLERGIES List all known.

Describe reaction and management of the reaction.

Medication allergies (list)

Food allergies (list)

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

Use this space to provide any additional information about the participant's behavior, physical, emotional, or mental health about which the camp should be aware. Please be assured that all information provided on this form will be kept confidential.

ALL MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____

Med #3 _____ Dosage _____ Specific times 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: _____

MEDICATIONS ADMINISTERED DURING CAMP

- Must be accompanied by a doctor's written order
- Keep in original packaging/bottle that identifies the prescribing physician (if prescription drug), the name of the medication, dosage, and frequency of administration
- Please provide sufficient medications for entire camp session
- All medications will be administered/stored by camp nurse

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

- Does not drink milk
- Does not eat ice cream
- Does not eat other dairy products
- Other (describe) _____
- Does not eat red meat
- Does not eat poultry
- Does not eat fish
- Does not eat eggs

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

General Questions (Explain "yes" answers below)

Has/does the participant:	Yes	No	Yes	No
1. Had a recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>		
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>		
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>		
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>		
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>		
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>		
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>		
8. Wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>		
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>		
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>		
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>		
15. Been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>		
16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>		
17. Ever had problems with joints (e.g. knees, ankles)?			<input type="checkbox"/>	<input type="checkbox"/>
18. Have an orthodontic appliance being brought to camp?			<input type="checkbox"/>	<input type="checkbox"/>
19. Have any skin problems (e.g. itching, rash, acne, eczema)?			<input type="checkbox"/>	<input type="checkbox"/>
20. Have diabetes?			<input type="checkbox"/>	<input type="checkbox"/>
21. Have asthma?			<input type="checkbox"/>	<input type="checkbox"/>
22. Had mononucleosis in the past 12 months?			<input type="checkbox"/>	<input type="checkbox"/>
23. Had problems with diarrhea/constipation?			<input type="checkbox"/>	<input type="checkbox"/>
24. If female, have an abnormal menstrual history?			<input type="checkbox"/>	<input type="checkbox"/>
25. Ever had an eating disorder?			<input type="checkbox"/>	<input type="checkbox"/>
26. Ever had emotional difficulties for which professional help was sought?			<input type="checkbox"/>	<input type="checkbox"/>

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

Date of last medical examination: _____

Which of the following has the participant had?

Please give all dates of immunization for (or attach immunization form from M.D.)

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

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	_____	_____	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____	_____

TB Mantoux Test
 Date of last test _____
 Result: Positive Negative

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. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer over the counter and/or prescribed medications with doctor's orders only, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child.

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 with the understanding that the family will be notified as soon as possible. This completed form may be photocopied for trips out of camp.

I also understand and agree to abide by any restrictions placed on my child's participation in camp activities.

Signature of parent/guardian _____

Printed name _____ Date _____

Health Care Recommendations by Licensed Medical Personnel

I examined the individual on _____. (Exam must be within past 18 months of camp attendance)

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:

Recommendations and Restrictions at Camp

Treatment to be continued at camp

Medications, including over-the-counter, to be administered at camp (name, dosage, frequency); **MUST BE ACCOMPANIED BY A DOCTOR'S WRITTEN ORDER.**

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 the camp

Signature of Licensed Medical Personnel _____ Printed _____ Title _____ Address _____ Phone _____ Date _____
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For camp use only

Screening Record Date screened _____ Meds received _____ Updates/additions to health history noted <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None required Current health needs identified _____ Observational notes _____ Screened by _____
