

Haycock Camping Ministries

Please do NOT mail this form to camp! Bring it with you to registration.

Health History and Examination Form

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. Health history must be filled out by parents/guardians of minors or by adults themselves. Health exam (last page) must be completed by approved licensed medical personnel. Update required annually.

Camper name _____ Birthdate _____ Age at camp _____

Home address _____

Gender: Male Female

Custodial parent/guardian name _____ Phone _____

Home address _____ Cell phone _____

Second parent or guardian or emergency contact _____

Address _____ Phone _____

If not available in an emergency, notify:

Name _____

Relationship _____ Phone _____ Cell phone _____

Address _____

Insurance Information

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

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

Important – These boxes must be complete for attendance.

► Photocopy of front and back of health insurance card must be included with this form.

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 prescribed medications, 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 me/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. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staffer _____

Printed name _____ Date _____

Minor or Staffer: I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or staffer _____ Date _____

Health History

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 to this form should be provided to camp health personnel. Provide complete information so that the camp can be aware of your needs.

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.

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medication 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 not/may not take during the summer: _____

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

Does not eat red meat

Does not eat pork

Does not eat eggs

Does not eat poultry

Does not eat seafood

Does not eat dairy products

Other (describe) _____

Activity

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

General Questions (Explain “yes” answers)

Has/does the participant:

1. Had recent injury, illness or infectious disease?... Y N
2. Have a chronic or recurring illness/condition?Y N
3. Ever been hospitalized?Y N
4. Ever had surgery?Y N
5. Have frequent headaches?Y N
6. Ever had a head injury?Y N
7. Ever been knocked unconscious?Y N
8. Wear glasses, contacts or protective eyewear? Y N
9. Ever had frequent ear infections? Y N
10. Ever passed out during or after exercise?Y N
11. Ever been dizzy during or after exercise?Y N
12. Ever had seizures?Y N
13. Ever had chest pain during or after exercise? Y N
14. Ever been diagnosed with a heart murmur?Y N
15. Ever had back problems?Y N
16. Ever had high blood pressure?Y N
17. Ever had problems with joints?Y N
18. Have an orthodontic appliance being brought to camp? Y N
19. Have any skin problems (itching, rash, acne)?..... Y N
20. Have diabetes? Y N
21. Have asthma? Y N
22. Had mononucleosis in the past 12 months? Y N
23. Had problems with diarrhea/constipation? Y N
24. Have problems with sleepwalking? Y N
25. Have a history of bed-wetting?Y N
26. Ever had an eating disorder?Y N
27. Ever had emotional difficulties for which professional help was sought? Y N

Which of the following has the participant had?

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> German measles | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Mumps | |

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

Please explain any “Yes” answers, noting the number of the questions:

Please give all dates of immunization for:

| | | | | | | |
|-------------------------|-------|-------|-------|-------|-------|-------|
| Vaccine: | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr |
| DTP | _____ | _____ | _____ | _____ | _____ | _____ |
| TD | _____ | _____ | _____ | _____ | _____ | _____ |
| Tetanus | _____ | _____ | _____ | _____ | _____ | _____ |
| Polio | _____ | _____ | _____ | _____ | _____ | _____ |
| MMR | _____ | _____ | | | | |
| or measles | _____ | _____ | | | | |
| or mumps | _____ | _____ | | | | |
| or rubella | _____ | _____ | | | | |
| Haemophilus influenza B | _____ | _____ | _____ | _____ | _____ | _____ |
| Hepatitis B | _____ | _____ | _____ | _____ | _____ | _____ |
| Varicella (chicken pox) | _____ | _____ | _____ | _____ | _____ | _____ |

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

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Licensed Medical Personnel

Health Care Recommendations

I examined this individual on_____. (Annual exam required)

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

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 _____

Camp Use Screened by _____
Observations/Notes _____
