

CAMP SCATICO

SUMMER 2009

CAMPER HEALTH HISTORY AND EXAMINATION FORM

Camper Name _____ **Gender** Female Male

Birth date _____ Age at Camp _____
Last First
Month / Day / Year

Name(s) of Parent(s) or Guardian(s) with whom the Camper lives: _____

Address of Camper's Primary Residence _____
Street Address City State Zip Country

Phone numbers of Primary Parent Contact _____
Home Cell Work Other

Second Parent Contact: _____
(must complete if a parent not living with the camper is also to be contacted whenever parent at home address is contacted)

Address of Second Parent Contact _____
Street Address City State Zip Country

Phone Numbers of Second Parent Contact _____
Home Cell Work Other

Insurance Information (attach photocopy of insurance card/s, front and back)

Name of Policy Holder _____ SS# _____ DOB _____

Employer Name & Address of Policy Holder _____

Insurance Co. Name _____ Insured ID# _____ Group # _____

Insurance Co. Address _____ Insurance Co. Phone # _____

Physician Information (Indicate the doctor(s) we should contact if necessary)

Name of Physician/Pediatrician _____ Phone _____

Name of Dentist/Orthodontist _____ Phone _____

Other _____ Phone _____

PERMISSION TO PROVIDE NECESSARY TREATMENT AND TO RELEASE MEDICAL INFORMATION:

I hereby give permission to the camp to provide routine health care, administer or dispense prescription and over-the-counter medications and seek medical treatment including ordering x-rays or tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes and to provide or arrange necessary transportation for my child. I authorize any physician, nurse or health care provider to communicate with the medical staff and directors of Camp Scatico, or their designees, about my child's medical condition, treatment, and/or prognosis. I further authorize the camp medical staff to discuss any medical conditions with the directors, or their designees, or my child's counselor, when the medical staff, in its sole discretion, believes such communication to be in the best interest of my child or in the best interest of the camp community. In the event that I, or any of the contacts listed above, cannot be reached in case of an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child. This completed form may be photocopied for trips out of camp. I also agree to abide by the restrictions placed on my child's camp activities.

Print Name _____ Signature _____ Relationship _____ Date _____

PARENT SIGN HERE

Camper Name: _____

The following information must be filled in by a parent or guardian and reviewed by a physician *within the past six months. The camp health personnel must be informed of any changes to this form upon arrival at camp.*

Place one check (✓) in the appropriate column that corresponds to each item below. *If "yes" provide details and dates:*

	Yes	No		Yes	No		Yes	No
High Blood Pressure			Insomnia			Frequent Diarrhea Constipation		
Convulsive Disorder			Skin Rashes			Shortness of Breath		
Diabetes			Seasonal Allergies			Recent Weight Loss/Gain		
Emotional Problems			Frequent UTIs			Smoke Cigarettes		
Headaches			Anemia			Fifth's Disease / /		
Asthma			Heart Disease			Chicken Pox / /		
Bleeding Problems			Eating Disorder			Measles / /		
Depression/Anxiety			Hepatitis A,B,C			Mumps / /		
Bedwetting			Lice/Scabies			Rubella / /		

If answered "yes", please provide specific details _____

Any other history of medical conditions or surgical procedures: _____

ALLERGIES

List Medication allergies

Is camper receiving regular allergy shots? Yes No

Describe *reaction* and *management of the reaction*.

List Food allergies

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

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New York State Public Health Law, Chapter 2164, requires that all campers/staff complete and submit the following information. CHECK ONE (1) BOX ONLY AND SIGN BELOW.

- My child has had the meningococcal meningitis immunization (Menomune) within the past 10 years.
Date Received: _____
- My child has had the meningococcal meningitis immunization (Menactra TM).
Date Received: _____
- I have read, or have explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.

Print Name _____ Signature _____ Relationship _____ Date _____

PARENT SIGN HERE

Camper Name: _____

Please give DATES for ALL DOSES for the following immunizations:

Tetanus-Diphtheria-Pertussis (Tdap)

1. Completed primary series of four doses with DTaP, DTP, DT or TD:...../_____/_____/_____/_____
Month Day Year
2. Booster: **Tdap** (preferred) to replace a single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on age of patient...../_____/_____/_____/_____
Month Day Year
3. Booster: Td within the last ten years...../_____/_____/_____/_____
Month Day Year

(OR)

Haemophilus (HIB) #1____/____/____ **#2**____/____/____ **#3**____/____/____
Month Day Year Month Day Year Month Day Year

Polio #1____/____/____ **#2**____/____/____ **#3**____/____/____ **#4**____/____/____
Month Day Year Month Day Year Month Day Year Month Day Year

Varicella (chicken pox) #1____/____/____ **#2**____/____/____
Month Day Year Month Day Year

MMR #1____/____/____ **#2**____/____/____ **or Measles #1**____/____/____ **#2**____/____/____
Month Day Year Month Day Year Month Day Year Month Day Year

or Mumps #1____/____/____
Month Day Year

or Rubella #1____/____/____
Month Day Year

Hepatitis A #1____/____/____ **#2**____/____/____
Month Day Year Month Day Year

Hepatitis B #1____/____/____ **#2**____/____/____ **#3**____/____/____
Month Day Year Month Day Year Month Day Year

Camper is under the care of a physician for the following condition/s:

Current treatment at the time of this report includes: _____

Treatment to be continued at camp: _____

Description of any limitation or restriction on camp activities, including dietary restrictions: _____

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: _____

Parent/Guardian Authorization: This health history is correct and complete as far as I know, and my child has permission to engage in all camp activities **except as noted**. I will advise the camp of any changes to this form upon arrival at camp.

Print Name _____ Signature _____ Relationship _____ Date _____

PARENT SIGN HERE

