

Health History and Examination Form FM 08N for Children, Youth, and Adults Attending Camp

Developed based on information supplied by: The American Camping Association, Inc., The American Medical Association and The American Academy of Pediatrics

RETURN TO:
(At least one month prior to beginning of camp.)

**Eagle Lake Camp
Camp Forms
PO Box 6819
Colorado Springs, CO 80934**

The information on this form is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians of minors or by adults themselves.

Update required annually. Health exam (back page) must be completed by approved licensed medical personnel at least every two years.

Name _____ Birth Date _____ Age at camp _____

Home Address _____ Home Phone _____
Last First Middle Initial *Street Address City State Zip Code* *Area/Number*

Social security number of participant (optional) _____ Gender: Male Female

Custodial parent/guardian _____ Cell Phone _____

Home Address _____ Work Phone _____
(If different from above) *Street Address City State Zip Code* *Area/Number*

Second parent/guardian _____ Cell Phone _____

Home Address _____ Work Phone _____
(If different from above) *Street Address City State Zip Code* *Area/Number*

If not available in an emergency, notify: _____

Relationship _____ Phone _____
Area/ Number

Insurance Information

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

If so, indicate plan name _____ Group # _____

Claims Address _____

Insurance Carrier's Name _____ Date of Birth _____ Social Security# _____

► Photocopy of front and back of health insurance card must be attached to this form.

Important Information – Please Read Carefully

- All four sides of this medical form must be fully completed with **signatures** and **returned** to Eagle Lake **one month** prior to the beginning of camp.
 - Camper must have had a **tetanus immunization within the previous 10 years**.
 - Camper must have had a **physical within previous 24 months** of camp dates. This must be **signed by a physician**, physician assistant, or nurse practitioner. If you are unable to secure an appointment before camp, you may substitute another physical exam report such as a sports or school physical. However, the substituted report must be signed by a physician, physician assistant, or nurse practitioner. This form must still be completed by the parent along with substituted report. We cannot use forms from previous years, please submit a new health form every year.
 - All **prescription medication** must be in the **original pharmacy container** labeled with the **child's name**, the **name of the drug**, and **instructions** for administration. It is illegal for our health office to dispense medication from improperly labeled containers.
 - Individuals with a **preexisting** medical condition or illness (especially a **contagious illness**) **cannot be admitted** and will be sent home as soon as possible at parental expense. Any registration payment made to the camp will not be refunded.
- *** If all of these requirements are not met, the health officer may refuse the camper admittance at registration.

Important – These boxes must be complete for attendance*

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal

representatives" for the purpose of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

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 or guardian or adult camper/staffer _____

Printed Name _____ Date _____

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

Signature of minor or adult camper/staffer _____ Date _____

General Questions (Explain "yes" answers below)

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

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

Which of the following has the participant had?

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

TB Mantoux Test

Date of last test _____

Result: Positive Negative

Please give all dates of immunization for:

Vaccine:	Dates:	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 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 _____

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 upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES. List all know.

Medication allergies (list)

Describe reaction and management of the reaction.

_____	_____
_____	_____
_____	_____

Food allergies (list) – please contact the Eagle Lake office if your camper is in need of a specific food regimen because of a medical condition. We want and need to have a clear understanding of the individual's dietary needs.

_____	_____
_____	_____
_____	_____

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

_____	_____
_____	_____
_____	_____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription drugs and vitamins) that are 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** medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____ Specific time taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific time taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific time 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: _____

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) _____

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

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____.

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 Eagle Lake Camp _____

Signature of Licensed Medical Personnel (required) _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

For camp use only

Screening Record

Date screened _____ Time _____ am
pm

Meds received _____

Updates/additions to health history noted Yes No None required

Current health needs identified _____

Observation notes _____
