



Please Attach Camper Photo Here

HEALTH HISTORY & EXAMINATION FORM

Parents: Please complete front

Physician: Please complete back

Camper Last Name _____ Date of Birth ____/____/____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____

Mother/Guardian's Name _____ Phone(____) _____

Business Phone (____) _____ Cell Phone (____) _____

Father/Guardian's Name _____ Phone(____) _____

Business Phone (____) _____ Cell Phone (____) _____

Camper lives with _____

If not available, in an emergency, notify the following, listed in order of preference: (a minimum of two names at separate addresses is required)

1)Name _____ Relationship _____ Phone(____) _____

Business Phone(____) _____ Cell Phone (____) _____

2)Name _____ Relationship _____ Phone(____) _____

Business Phone(____) _____ Cell Phone (____) _____

3)Name _____ Relationship _____ Phone(____) _____

Business Phone(____) _____ Cell Phone (____) _____

If traveling/vacationing, please indicate how we may reach you:

Insurance Information

Policy Holder _____ Insurance Company _____

Insurance Policy Number _____ Social Security Number _____

Check all that apply:

____ Has Diabetes _____ Sleepwalks _____ Abnormal Menstrual History

____ Has Epilepsy/Prone to seizures _____ Wets Bed _____ Emotional Difficulties

____ Has Asthma** _____ Head Aches _____

____ Had/Has an eating disorder _____ Ear infections _____ Had mononucleosis in the past 12 months

____ Any recent injury _____

____ Had any infectious disease _____

Requires an Epi Pen _____ ** Allergies: _____

**Additional form required for possession of Asthma inhaler or Epi-Pen. Form is located on our website.

In case of emergency, I hereby give permission to the physician selected by the Camp to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child, as named. (Every effort will be made, if possible, to contact the parents in event of emergency.) If my daughter/son requires extended medical care by a physician or hospital, I will be responsible, through my insurance carrier, for all expenses incurred above the camp's limited policy. I give permission to the medical personnel selected by the camp director to provide routine health care for common ailments and injuries; to administer medications and/or treatments that the nurse deems necessary, under the guidance of the overseeing Physician and/or Nurse Practitioner during my child's stay at Camp Huckins. I give permission for Camp Huckins to administer over-the-counter medications if the nurse deems it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

Signature of Parent or Guardian _____ Date _____

Name of Physician: _____

Business Phone: _____ Emergency Phone: _____

Name of Dentist: _____ Phone: _____

Name of Orthodontist: _____ Phone: _____

PHYSICIANS STATEMENT & IMMUNIZATION RECORD

Camper's Name _____ **Birth Date** ___/___/___

Which of the following diseases has the patient had?

Please give all dates of immunization for:

- ___ Rubella
- ___ Varicella
- ___ Mumps
- ___ Hepatitis A
- ___ Hepatitis B

TB Mantoux Test:
Date of last test _____
Results _____

Vaccine:	Date	Date	Date	Date	Date	Date
DTaP/DTP/DT						
Tdap/Td						
Polio						
MMR						
2009 H1N1 Influenza						
Hepatitis A						
Hepatitis B						
Haemophilus influenza B						
Varicella(chicken pox)						

I examined the above named on: _____ (Date).
Height _____ Weight _____ BP _____

In my opinion, the above applicant IS IS NOT able to participate in an active camp program.

The Participant is under the care of a physician for the following condition: _____

Recommendations and Restrictions at Camp. Treatment to be continued at camp: _____

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

Known Allergies _____

Dietary Restrictions _____

Signature _____

Signature of Licensed Medical Personnel

Print Name _____

Title _____ Date _____

Address _____ Phone _____

Screening Record (For camp use only) Screened by _____

Date Screened _____ Time _____ am / pm Updates/additions to health history noted Y N NA

Meds received _____

Current health needs identified _____

Observational notes _____