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## MEDICAL FORM

PLEASE RETURN THIS  
FORM BY JUNE 1!!

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Home Address \_\_\_\_\_

Staff Social Security No. \_\_\_\_\_ Age at camp \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_

Second Parent/Guardian/Emergency Contact \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_

If not available in an emergency, notify \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

### Insurance Information:\*

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

If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

**\*A photocopy (front/back) of health insurance card must be attached to this form.**

### IMPORTANT – THESE BOXES MUST BE COMPLETE FOR ATTENDANCE

**Parent/Guardian Authorization:** This health history is correct and complete as far as I know. The person herein described has my permission to engage in all camp activities except as noted.

I hereby give my 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 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 medical 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/staff \_\_\_\_\_

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/staff \_\_\_\_\_ Date \_\_\_\_\_

**Health History:** The following information must be filled in by the parent/guardian, or adult camper/staff. Please notify us of any changes to this form before your son arrives at camp.

**ALLERGIES:** List all known  
**Medication allergies** (list)

Describe reaction and management of the reaction.

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**Food Allergies** (list)

Describe reaction and management of the reaction.

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**Other allergies** (insect stings, hay fever, etc.)

Describe reaction and management of the reaction.

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**MEDICATIONS BEING TAKEN:** Please list ALL medication (including over-the-counter or nonprescription drugs) taken routinely.

This person takes **NO** medication on a routine basis

This person takes medications as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
 Generic substitute is acceptable  
Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
 Generic substitute is acceptable  
Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
 Generic substitute is acceptable  
Reason for taking \_\_\_\_\_

#### RESTRICTIONS

##### Dietary

- Does not eat red meat     Does not eat pork     Does not eat eggs     Does not eat dairy products  
 Does not eat poultry     Does not eat peanuts     Does not eat tree nuts  
 Other (describe) \_\_\_\_\_

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

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**General Questions** (Explain “yes” answers below)

Has/does the participant	Yes	No
1. Had any 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 or migraines?.....	<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. Ever 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, shoulders)? .....	<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)?.....	<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. Have problems with sleepwalking? .....	<input type="checkbox"/>	<input type="checkbox"/>
25. Have a history of bed-wetting? .....	<input type="checkbox"/>	<input type="checkbox"/>
26. Ever had an eating disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>
27. Ever had emotional difficulties for which professional help was sought? .....	<input type="checkbox"/>	<input type="checkbox"/>
28. Ever been diagnosed with learning disabilities, ADD, ADHD, or the such? .....	<input type="checkbox"/>	<input type="checkbox"/>

**Please explain any “yes” answers, noting the number of the questions.** (Attach additional sheet if necessary)

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**Use this space to provide any additional information about camper/staff member’s behavior and physical, emotional, or mental health of which camp should be aware.**

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Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

**To be completed by Licensed Medical Personnel**

Which of the following has the camper/staff had? <input type="checkbox"/> Measles <input type="checkbox"/> Chicken Pox <input type="checkbox"/> German Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C  TB Mantoux Test Date of last test _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Please give dates of immunization for: Vaccine:            Date:    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 B _____ Varicella (chicken pox) _____
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I examined this individual on \_\_\_\_\_ BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, this individual  is  is not able to participate in an active camp program.

This individual is under the care of a physician for the following conditions  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Recommendations and Restrictions at Camp**

Treatment to be continued at Camp Nebagamon  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Any medically-prescribe meal plan or dietary restrictions  
 \_\_\_\_\_  
 \_\_\_\_\_

Know allergies  
 \_\_\_\_\_  
 \_\_\_\_\_

Description of any limitation or restriction on camp activities  
 \_\_\_\_\_  
 \_\_\_\_\_

Additional information for health care staff at Camp Nebagamon  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature of Licensed Medical Personnel _____ Printed _____ Title _____ Address _____ Phone _____ Date _____
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