

⑤ a

MEDICAL FORM

PLEASE RETURN THIS
FORM BY MAY 15!!

Name _____ D.O.B. _____

Home Address _____

Camper 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.

Food Allergies (list)

Describe reaction and management of the reaction.

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

Describe reaction and management of the reaction.

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)

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)

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.

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?	Please give dates of immunization for:								
<input type="checkbox"/> Measles	Vaccine: DTP	Date: _____	Mo/Yr _____	Mo/Yr _____	Mo/Yr _____	Mo/Yr _____	Mo/Yr _____	Mo/Yr _____	Mo/Yr _____
<input type="checkbox"/> Chicken Pox	TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German Measles	Tetanus	_____	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Polio	_____	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	MMR	_____	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Measles	_____	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Mumps	_____	_____	_____	_____	_____	_____	_____	_____
	or Rubella	_____	_____	_____	_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B	_____	_____	_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B	_____	_____	_____	_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (chicken pox)	_____	_____	_____	_____	_____	_____	_____	_____

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 _____