

IMPACT 2010

Health Form

This side to be filled in by parents/guardian of minors or by adult campers/staff

Name _____ Birthdate _____ Sex _____ Age _____
Last First Initial

Social Security No. _____ Parent or Guardian (or Spouse) _____

Home Address _____ Phone _____
Street and Number City State Zip Area/Number

Business _____

Second Parent or Guardian or Emergency Contact _____

Home Address _____ Phone _____
Street and Number City State Zip Area/Number

Business Address _____ Phone _____
Street and Number City State Zip Area/Number

If not available in an emergency, notify:

Name _____

Address _____ Phone _____
Street & Number City State Zip Area/Number

Has this camper ever required psychiatric counseling or hospitalization? _____

Explain _____

Operations or serious injuries (dates) _____

Disability or chronic or recurring illness _____

Activities encouraged or limited by physician _____

Dietary modifications _____

Current medications (send with instructions) _____

Other diseases or details of above _____

Name of dentist/orthodontist _____ Phone _____

Name of family physician _____ Phone _____

Date of last physical examination _____

Do you carry family medical/hospital insurance? Yes _____ No _____

If so, indicate: Carrier _____ Policy or Group # _____

Suggestions on health related information for camp personnel

For Female

Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special consideration _____

Health History:

Check. Give approximate dates

Frequent Ear Infections _____

Heart Defect/Disease _____

Convulsions _____

Diabetes _____

Bleeding or _____

Clotting Disorders _____

Hypertension _____

Mononucleosis _____

Psychiatric Treatment _____

Diseases

Chicken Pox _____

Measles _____

German Measles _____

Mumps _____

Allergies

Hay Fever _____

Ivy Poisoning, etc. _____

Insect Stings _____

Penicillin _____

Other Drugs _____

Asthma _____

Other (Specify) _____

Important -This Box Must Be Completed for Attendance*

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine test, treatment, and necessary transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp. **Permission to photo:** I hereby give permission to the officials at camp to take still, video, and digital pictures of me/or my child for the use of the camp in promotional publications, print, video, and on the World Wide Web.

Signature of parent or guardian or adult camper/staffer _____

Witness _____ Date _____

*If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver, which must be signed for attendance.

Immunization History

This side to be filled in by Physician

Please record the date (month & year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria	1	1
Pertussis (Whooping Cough) DPT	2	2
Tetanus	3	
Or		
Tetanus Diphtheria TD		
Or		
Tetanus		
Oral Polio (Sabin) TOPV		
Injection Polio (Salk)		
Measles (hard measles, red measles, Rubella)		
Mumps		
Rubella (German Measles, 3-day measles)		
Other		
Tuberculin Test (most recent)		
Haemophilus influenza (HIB)		

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant within the past two years. Date examined _____

In my opinion, the above's condition (___ does not ___ does) preclude his/her participation in an active camp program.

Height _____ Weight _____ Blood Pressure _____

Applicant is under the care of a physician for the following condition(s): _____

Current treatment (include current medications) _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Does applicant have epilepsy? ___ Yes ___ No Does applicant has diabetes? ___ Yes ___ No

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp _____

Any medications to be administered at camp (specific dosages) _____

Any medically prescribed meal plan or dietary restrictions _____

Any allergies (food, drugs, plants, insects, etc.) _____

Additional Health Information _____

Licensed Physician's Signature _____

Address _____

Street & Number
City
State
Zip
Phone
Area/Number

Date of Form Completion _____ By _____
Initial if completed by nurse or physician's assistant.