

CAMP HEALTH HISTORY AND EXAMINATION FORM FOR CHILDREN, YOUTH AND ADULTS

This is to be filled on by parents/guardians of minors or by adult campers/staff members themselves.

Name _____ Birth Date _____ Sex _____ Age _____

Parent or Guardian (or spouse) _____ Phone _____

Home Address _____
Street & Number Apartment City State Zip Code

Business Address _____
Street & Number Apartment City State Zip Code

Second Parent or Guardian or Emergency Contact _____

Home Address _____
Street & Number Apartment City State Zip Code

Business Address _____
Street & Number Apartment City State Zip Code

If either of above not available, in an emergency, notify:

Name _____ Phone _____

Home Address _____
Street & Number Apartment City State Zip Code

Health History: Has/does the participant had/have (please check yes or no & give approximate date, explain any yes answers to questions marked with * below)

	Yes	No	Date		Yes	No	Date		Yes	No	Date
Frequent Ear Infections	[]	[]	[]	Mononucleosis	[]	[]	[]	Hay Fever	[]	[]	[]
Heart Defect/Disease*	[]	[]	[]	Chicken Pox	[]	[]	[]	Ivy Poisoning	[]	[]	[]
Convulsions*	[]	[]	[]	Measles	[]	[]	[]	Insect Stings	[]	[]	[]
Diabetes*	[]	[]	[]	German Measles	[]	[]	[]	Penicillin	[]	[]	[]
Bleeding/Clotting Disorders*	[]	[]	[]	Mumps	[]	[]	[]	Other Drugs	[]	[]	[]
Hypertension*	[]	[]	[]	Asthma *	[]	[]	[]				

Please explain any "yes" questions marked with an * _____

Operations or serious injuries _____

Disability or chronic or recurring illness _____

Any specific activities to be encouraged or limited by physician's advice? _____

Dietary Modifications _____

Current Medications (send with instructions) _____

Suggestions or other health related information you wish us to know: _____

Physician Name _____ Phone _____ Date of last Physical Exam _____

Dentist/Orthodontist Name _____ Phone _____

IMPORTANT: PARENT/GUARDIAN MUST FILL OUT THE FOLLOWING INSURANCE SECTION

Do you carry family medical/hospital insurance? You must check one of the boxes YES [] NO [] If yes, indicate:

Carrier _____ Policy or Group Number _____

* For females: Has this person menstruated? _____ If not, have they been told about it? _____
 If so, is her menstrual history normal? _____ Special consideration _____

IMPORTANT- PARENT/GUARDIAN & CAMPER MUST SIGN BELOW FOR CAMP ATTENDANCE

This health history is correct as far as I know, and the person described herein described has permission to engage in all camp activities except as noted above.

I hereby give permission to for a Camp Wilbur Herrlich Staff member selected by the medical personnel and Camp Directors to provide for medical treatment at the Camp Physicians Office as needed. I also give permission for a designated Camp Wilbur Herrlich Staff member to pick up any prescriptions related to the care of my child at the pharmacy.

Emergency Authorization: I hereby give permission to the medical personnel selected by the Camp Director to order X-rays, routine tests and treatment for 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 hospitalize, secure proper treatment for and to order injections and/or anesthesia and/or surgery for my child named above. This form may be photocopied for use out of the camp.

Signature of Parent or Guardian _____ Date _____

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of Minor _____

****Your camper will NOT be registered for camp until this form is completely filled out and signed in the appropriate areas.****

IMMUNIZATION HISTORY

Required immunization must be determined locally. Please record the date (month and year) of basic immunization and most recent booster doses.

Vaccination	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) DPT Tetanus	1 2 3	1 2
Tetanus Diphtheria TD		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3 Day measles)		
HIB (Haemophilus Influenza type B)		
HEP B		
Varicella (Chicken Pox)		
Tuberculin test given ____ (most recent)		

HEALTH EXAMINATION BY LICENSED PHYSICIAN

I have examined the camp applicant _____ on Date _____

In my opinion, his/her condition does _____ does not _____ preclude him/her from normal camp activities.

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

Current Treatment (include any medication): _____

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

Does applicant have epilepsy? Yes _____ No _____ Does applicant have diabetes? Yes _____ No _____

Any treatments to be continued at camp: _____

Any medication to be administered at camp (specific dosage): _____

Any medically prescribed meal plan or dietary restrictions: _____

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

FOR PHYSICIAN- PLEASE FILL OUT FOLLOWING INFORMATION

Licensed Physicians Signature _____ Printed Name _____

Address _____ Phone _____ Date _____

For Camp Use Only

Screening Record

Date Screened _____ Medications Received _____

Observational Notes _____

Current health needs identified _____ Screened by _____

MOUNT TREMPER OUTDOOR MINISTRIES
CAMP WILBUR HERRLICH
 101 Deacon Smith Hill Road, Patterson, New York 12563
 Phone: 845-878-6662 Fax: 845-878-2030 www.campherrlich.org

THE FOLLOWING INFORMATION **MUST** BE COMPLETED AND **SIGNED BY A PHYSICIAN**. THIS FORM MUST ACCOMPANY THE CAMP HEALTH HISTORY FORM IN ORDER PRIOR TO YOUR CHILD'S ATTENDANCE AT CAMP. APPROVAL MUST BE GRANTED FOR *NON-PRESCRIPTION* AS WELL AS *PRESCRIPTION* MEDICATIONS TO BE ADMINISTERED TO YOUR CHILD.

INDIVIDUAL ORDERS for: Camper's Name _____ DOB: _____ Weight _____

Standard Over the Counter/PRN Medications (The following medications are available in the Infirmary and will be administered at the discretion of our camp nurse, if approval is indicated by the camper's healthcare provider.):

Drug Name	Route (please circle preferred formulation(s))	Dosage	Schedule and Indications	Camper Health Care Provider Order	Comments
Tylenol	PO (chewable tabs, elixir or tabs)	Per label instructions by age/weight	Q 4 hr prn for pain or fever > _____ F°	Yes No	
Ibuprofen	PO (chewable tabs, suspension, or tabs)	Per label Instructions by age/weight	Q 6 hr prn for pain or fever > _____ F°	Yes No	
Robitussin DM	PO (syrup)	Per label instructions by age/weight	Q 4 hr prn for cough	Yes No	
Pepto-Bismol	PO (liquid, or chewable tabs)	Per label instructions by age/weight	BID-TID prn for stomach upset	Yes No	
Kaopectate	PO (liquid)	Per label instructions by age/weight	Q 30 min to 1 hr prn for diarrhea (no>8 doses/24 hr)	Yes No	
Benadryl	PO (elixir, chewable tabs or pills)	Per label instructions by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)	Yes No	
Sudafed	PO (elixir or tabs)	Per label instructions by age/weight	Q 6-8 hrs prn for nasal congestion/drainage	Yes No	

Prescription Medications (Please complete with patient's current regimen for both scheduled and prn medications.)

Drug	Route	Dosage	Schedule and Indications	Comments

Camper's Health Care Provider Name: _____ Phone # _____

Address: _____ License # _____

Signature: _____ Date: _____