2010 CAMPER HEALTH EXAMINATION FORM

Please mark camp(s) attending: ☐ **Playland** ☐ **Anisfield (including Maccabi Sports)** ☐ **Performing Arts**

Camper Name: ______________________ ☐ Male ☐ Female Birth Date: ______________ Age at Camp: ______

Home Address: ______________ City/State/Zip: ______________ Home Phone Number: ______________

Parent Name: ______________ Work Phone Number: ______________ Cell Phone Number: ______________

Parent Name: ______________ Work Phone Number: ______________ Cell Phone Number: ______________

IN THE CASE A PARENT CAN NOT BE REACHED, PLEASE CONTACT:

1. Name: ______________ Phone: ______________ Relationship: ______________
2. Name: ______________ Phone: ______________ Relationship: ______________

Pediatrician Name: ______________ Phone: ______________

Pediatrician Address: ______________

Dentist/Orthodontist Name: ______________ Phone: ______________

Dentist/Orthodontist Address: ______________

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY)

Name of Contract Holder: ______________ Relationship to Camper: ______________

Carrier Name: ______________ Carrier Address: ______________ Insurance ID Number: ______________

Certificate Number: ______________ Group or Policy Number: ______________ If Blue Cross: BC of (City) ______________

PARENT'S OR GUARDIAN'S CONSENT

1. The information provided on this form is correct and complete as far as I know, and my child has permission to engage in all camp activities except as noted.
2. I hereby authorize the camp director or camp medical staff to act on my behalf according to their best judgment. I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests or treatment, to arrange necessary related transportation for my child and to release any records necessary for insurance purposes. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, anesthesia or surgery for my child. This completed form may be photocopied for trips out of camp.
3. I hereby authorize the release of any information in connection with this form that the hospital or physician in their sole discretion may deem proper.
4. I hereby authorize payment of medical benefits to the camp's designated physician, provider or hospital for ser vices described herein.

Insurance Certificate Holder Signature ______________ **Date** ______________

Parent or Guardian Signature ______________ **Date** ______________

HEALTH HISTORY (General Questions – Explain "Yes" Answers Below)

	Has/Does the camper:	Yes	No
1.	Had any recent injury, illness or infectious diseases?	☐	☐
2.	Have a chronic or recurring illness/condition?	☐	☐
3.	Ever been hospitalized?	☐	☐
4.	Ever had surgery?	☐	☐
5.	Have frequent headaches?	☐	☐
6.	Ever had any serious injuries?	☐	☐
7.	Wear glasses, contacts or protective eye wear?	☐	☐
8.	Ever had frequent ear infections?	☐	☐
9.	Ever been dizzy or passed out during or after exercise?	☐	☐
10.	Ever had seizures or other epileptic symptoms?	☐	☐
11.	Ever had high blood pressure?	☐	☐
12.	Ever had heart trouble?	☐	☐
13.	Ever had back trouble?	☐	☐

		Yes	No
14.	Ever had problems with joints (knees, ankles, etc.)?	☐	☐
15.	Have an orthodontic appliance brought to camp?	☐	☐
16.	Have any skin problems (itching, rash, acne, etc.)?	☐	☐
17.	Have diabetes?	☐	☐
18.	Have asthma?	☐	☐
19.	Had mononucleosis within the past 12 months?	☐	☐
20.	Had problems with diarrhea/constipation?	☐	☐
21.	Have problem with sleepwalking?	☐	☐
22.	If female, have an abnormal menstrual history?	☐	☐
23.	Have a history of bed-wetting?	☐	☐
24.	Have an eating disorder?	☐	☐
25.	Ever had emotional difficulties for which professional help was sought?	☐	☐
26.	Other?	☐	☐

Please explain any "yes" answers, noting the number of the questions: ______________

____

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(OVER)

CAMPER HEALTH HISTORY (continued)

NAME: ______________________________

MENTAL, EMOTIONAL AND PSYCHOLOGICAL HEALTH

	Has/Does the camper:	Yes	No			Yes	No
1.	Has an emotional health concern that will impact camp participation?	☐	☐	3.	Has a significant life event that continues to affect the camper's life/health?	☐	☐
2.	Has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder?	☐	☐	4.	Uses an individualized learning plan at school?	☐	☐

If "yes" was the answer to any of the four statements above, attach a statement from your child's professional (e.g., physician, psychiatrist, therapist) that addresses the following with regard to your child's participation at camp:

a. Describes the concern and the camper's management plan (including medications) while at camp;
b. Describes the behaviors that will indicate to our staff that your camper needs professional referral; and
c. Provides a recommendation from this professional supporting your child's participation in our camp program.

PLEASE NOTIFY US IF CAMPER HAS BEEN EXPOSED TO ANY CONTAGIOUS DISEASES DURING THE 3 WEEKS BEFORE THE START OF THE CAMP SESSION.

Which of the following has camper ever had: ☐ Measles ☐ Chicken Pox ☐ German Measles ☐ Mumps ☐ Hepatitis ☐ Sinusitis ☐ Bronchitis ☐ Rheumatic Fever

PLEASE GIVE DATES OF MOST RECENT IMMUNIZATIONS FOR:

DTP	______	Polio	______	Haemophilus Influenza B	______
TD (Tetanus/Diphtheria)	______	Measles	______	Hepatitis B	______
Tetanus	______	Rubella	______		

MEDICATION ALLERGIES (list and describe reaction and management of the reaction): ______________________________

FOOD ALLERGIES (list and describe reaction and management of the reaction): ______________________________

OTHER ALLERGIES (list and describe reaction and management of the reaction) – include bee or other insect stings, hay fever, asthma, animals, etc.: ______________________________

MEDICATIONS – Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Include the name of medication, the dosage and frequency of administration. ______________________________

RESTRICTIONS – Please list dietary restrictions, specific activities to be avoided, or necessary adaptations or limitations: ______________________________

FOLLOWING MUST BE COMPLETED BY LICENSED MEDICAL PERSONNEL

I have examined the above listed camp participant. Date of last examination: ______________

BP: ______________ Weight: ______________ Height: ______________

In my opinion, the above applicant ☐**is** ☐**is not** able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions: ______________________________

Current treatment at the time of this report includes: ______________________________

Recommendations and Restrictions at Camp:

Any medications to be administered at camp (name, dosage, frequency) or medically-prescribed dietary restrictions: ______________________________

Any known allergies: ______________________________

Description of limitation or restriction on camp activities: ______________________________

Signature of Licensed Medical Personnel: ______________________ Date: ______________

Printed Name: ______________________ Title: ______________________

Address: ______________________________

City, State, Zip: ______________________ Phone: ______________________