



Camp Sentinel 2010 Health Form

Demographic and Emergency Contact Information

Camper Name: _____ Birth Date: _____ Age _____ Sex _____
Last First M

Home Address: _____ City _____ State _____ Zip: _____
Phone: () _____ Social Security Number of Camper: _____

Custodial Parent/Guardian and Emergency Contact Information

Parent/Guardian Name _____ Relationship to Camper _____

Home Address (if different from above) _____ City _____ State _____ Zip: _____

Home Phone: () _____ Cell Phone: () _____ Other Phone () _____

Business Address: _____ Phone: () _____

Name _____ Relationship to Camper _____

Home Address (if different from above) _____ City _____ State _____ Zip: _____

Home Phone: () _____ Cell Phone: () _____ Other Phone () _____

Insurance Information

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

Plan Name: _____ Group number _____

Policy Holder Name: _____ Relationship to Camper: _____

Social Security Number of Policy Holder or Insurance ID Number: _____

Health History

The Parent/Guardian or adult staff member must out the following information. The intent of this information is to provide camp health care personnel the background health information to provide appropriate care. If additional space needed, blank paper may be used and attached if necessary.

Allergies: list all known and describe reaction.

Medication Allergies (list)

Food Allergies (list)

Other Allergies (list) (dust, pollen etc.)

Medications:

Please list all medications including over the counter and prescriptive medications taken routinely. Please bring enough medication to last the entire time at camp. PLEASE keep medication in original packaging that identifies the medication to be given. Prescription medication should have name of medication, dosage, frequency of administration and prescribing physician on bottle or packaging that it came in.

This camper/staff member takes NO medications on a routine basis

This person takes medications as follows:

MED #1: _____ Dosage: _____ Specific times taken each day: _____

Reason for Taking: _____

MED #2: _____ Dosage: _____ Specific times taken each day: _____

Reason for Taking: _____

MED #3: _____ Dosage: _____ Specific times taken each day: _____

Reason for Taking: _____

If applicable to your child:

PERMISSION TO HOLD INHALER and/or EPI-PEN: I give permission for my child to hold his/her own Epi-Pen and/or Inhaler, and administer it as needed during his/her stay at camp. He/She has been trained in the appropriate administration of either an Epi-Pen and/or inhaler _____

Signature of Parent or Guardian





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Dietary Restrictions and/or Modifications

- Does not eat Red meat
- Does not eat pork
- Does not eat eggs
- Does not eat poultry
- Does not eat seafood
- Does not eat dairy Products
- Other (describe) _____

General Health Questions (explain any "yes" answers in space below)

Has/does the applicant....	Yes	No		Yes	No
Had any recent injury, illness or infectious disease?			Ever had back problems?		
Have a chronic or recurring illness/condition?			Ever had problem with joints?		
Ever been hospitalized?			Have an orthodontic appliance being brought to camp?		
Ever had surgery?			Have any skin problem (itching, acne, rash, hives...)		
Have frequent headaches?			Have diabetes?		
Ever had a head injury?			Have asthma?		
Ever been knocked unconscious?			Had mononucleosis in the past 12 months?		
Wear glasses, contacts, or protective eye wear?			Had problems with diarrhea/constipation?		
Ever had frequent ear infections?			Have problems with sleepwalking, talking or night terrors		
Ever passed out or been dizzy during or after exercise?			Have a history of bed wetting?		
Ever had seizure or seizure like activity?			Ever had an eating disorder?		
Ever had chest pain during or after exercise?			Ever had emotional difficulties for which professional help was sought?		
Ever had high blood pressure?			In past month has applicant been around any person with infectious illness (ex. flu like symptoms, colds, head lice etc.)		
Ever been diagnosed with a heart murmur or problem?			For female...has applicant menstruated, if no has she been told about it?		
Ever broken/fractured a bone?			For female...have history of abnormal menstrual cycle?		

Please explain yes answers _____

*** IMPORTANT — MUST BE COMPLETED FOR ATTENDANCE ***

Parent/Guardian Authorization: This part should be signed by the parent/guardian OR Adult Staff Member:

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 Xrays, 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. I further give permission to the camp medical personnel to administer prescription medication and over-the-counter medication (PRNs) to my child. 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 (parent or guardian or adult staff) _____

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.



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Physician or Medical Personnel Page

Health Care Recommendations by Licensed Medical Personnel: (Please fill out following or attach most recent records)

I examined the above camp applicant on _____. (Must be within the past 24 months)

In my opinion, the above applicant is is NOT able to participate in active camp program.

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Temp _____

The applicant is under the care of Physician or Medical Personnel for the following conditions:

The applicant's current treatments at this time (including medications):

Known **Allergies** _____

Does the applicant have Epilepsy? Yes No Does the applicant have Diabetes? Yes No

Recommendations and Restrictions at Camp

Treatment to be continued at camp:

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

Any medically-prescribed meal plan or dietary restrictions:

Description of any limitation or restriction on camp activities:

Additional information for health care staff at the camp

Vaccines	Year of Basic Immunization	Year of Last Booster
DPT- Diphtheria, Pertussis, Tetanus OR		
TD Tetanus, Diphtheria OR		
Tetanus		
Oral Polio (Sabin) TOPV		
Injection Polio (Salk)		
Measles (hard measles, red measles, Rubella)		
Rubella (German Measles, 3-day measles)		
Mumps		
Hepatitis A,B, and/or C		
Varicella		
Influenza		

TB Mantoux Test
Date of Last Test: _____

Result

- Positive
 Negative

Has the applicant had any of the following?
If so please give approximate date.

- Chicken pox
 Measles
 Mumps
 German measles

Signature of Licensed Medical Personnel:

Printed: _____ Title: _____

Address: _____

Your signature above also indicates that the above-named camper, if applicable, has been trained in the administration of an Epi-Pen and/ or Inhaler, may keep the Epi-Pen or Inhaler with them during camp, and may self-administer it as needed while at camp.

