Health History and EXamination of the complexity and Adults         for Children, Youth and Adults         Strugtistical for any set of the complexity of registric any matching complexity of registruc any matching complexity of registric any matching complexity		substant and Examination Form	Dates of Camp Aut	siluarios			
Attending Campus         Image: Suggestion for readed and approved by American Campung of Pediatrics American Sufficient Campung of Pediatrics American Campung		Health History and Examination Form for Children, Youth and Adults	Mail this form to t	he address bel	ow by	(date)	
Developed and approved by     American Camping Associations     American Academy of Padiatrics     Expire S123103     The information on this form is not part of the camper or staff     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is gathered to easist usin identifying     acceptance process, but is dentified to use process, but is dentified to use of the process of the easist use easist use of the easist use of the easist use of the easist use e	1	Attending Camps					
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30       The information on this form is the parages have be completed or synchronization in the parages in the par			themselves Undat	e required and	ually. Health	n exam (bac	
filled out by parents/guardinative stream       Birth date	Year	The information on this form is not part of the camper of the acceptance process, but is gathered to assist us in identifying					
Name		filled out by parents/guardians of minors of by user					
Name       First       Made       20         Home address			Didh data		Age at ca	mp	
Home address       Second security number of participant       Or       Second Prent Quardian       Phone         Custodial parent/Quardian       Phone       Phone       Phone         Home address       Second Parent or guardian or emergency contact       Phone       Phone         Business address       Second Parent or guardian or emergency contact       Phone       Phone         Business address       City       Second Phone       Phone         Address       Separations       Phone       Phone       Phone         Address       Group #       Phone       City       Second Phone       P		Name	Middle				
Social security number of participant       Phone         Custodial parent/guardian       Phone         Home address       State         Second parent or guardian or emergency contact       Phone         Address       City         Subiness address       City         Business address       City         Second parent or guardian or emergency contact       Phone         Address       City         Business address       City         Business address       City         Business address       City         Business address       Phone         Business address       Phone         Business address       Phone         Business address       Phone         Relationship       Phone         Address       Phone         Struct address       Phone         Relationship       Phone         Address       Phone         Struct address       Phone         Steat address       Phone		Last First	-		Charles	Zip	
Social security number of participant		Home address	City			•	
Custodial parent/guardian		Street acores		Gender.			
Home address       Sinverdedvise       Phone		Social security number of participant		Phone			
Home address       Sinverdedvise       Phone		Custodial parent/guardian	,				
Phone       Phone         Business address       City       Sub       Zp         Address       City       Sub       Zp         Business address       City       Sub       Zp         If not available in an emergency, notify:       Name       Phone       Phone         Address       City       Sub       Zb       Zb         Insurance information       Is the participant covered by family medical/hospital insurance?       Yes< <td>No       No         If so, indicate carrier or plan name      </td> <td></td> <td></td> <td>City</td> <td></td> <td>Sinte</td> <td>Zip</td>	No       No         If so, indicate carrier or plan name			City		Sinte	Zip
Business address       City       Sum       Zp         Second parent or guardian or emergency contact		Home address		Phone			
Second parent or guardian or emergency contact	I	Public address	State Z	p			
Second parent or guardian or emergency contact	dn	Business address City					
If not available in an emergency, notify:         Name	2	Second parent or guardian or emergency contact		Divers			
If not available in an emergency, notify:         Name	5		Chita 21	Phone			
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If not available in an emergency, notify:         Name	bin	Duciness address			2		
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Name		If not available in an emergency, noury:					
Relationship	· .				12		
Address       Cay       Set         Insurance information       Is the participant covered by family medical/hospital insurance?       I Yes       No         If so, indicate carrier or plan name		Name	·	Phone			
Address       Cay       Set         Insurance information       Is the participant covered by family medical/hospital insurance?       I Yes       No         If so, indicate carrier or plan name		Relationship	· · · · · · · · · · · · · · · · · · ·				
Insurance information         Is the participant covered by family medical/hospital insurance?       Yes       No         If so, indicate carrier or plan name		Address	. City	•	Stade	Zip	
Insurance information         Is the participant covered by family medical/hospital insurance?       Yes       No         If so, indicate carrier or plan name		Street address	6		• •.	· · · · .	
Is the participant covered by family medical/hospital insurance?Group # f so, indicate carrier or plan nameGroup # Photocopy of front and back of health insurance card must be attached to this form. Important — These boxes must be complete for attendance* Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. agree to the release of any records necessary for treatment, Signature of parent/guardian or adult camper/staffer Date I also understand and agree to abide by any restrictions placed on my participation in camp activities. Signature of minor or adult camper/staffer Date		24	3	<b>3</b> 2 0.000 0.001	5 3		
If so, indicate carrier or plan name			e? Yes No			•	
If so, indicate carrier or plan name		is the participant covered by family medical/hospital incertain		Group #			
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and complete as far as 1know. The personnecept as noted.       In the event I cannot be reached in an emergency, ineracy give permission to engage in all camp activities except as noted.         I hereby give 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 treatment, Signature of parent/guardian or adult camper/staffer Date       In the event I cannot be reached in an emergency, ineracy give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person and advected form may be photocopied for trips out of camp.         Signature of parent/guardian or adult camper/staffer		Parent/Guardian Authorization: This health history is correct	camp to arrange necessary related to appropriate theraby give				
permission to drigge 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 treatment, Signature of parent/guardian or adult camper/staffer Date       permission to the physicial selected form may be photocopied for trips administer 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/staffer       Date         I also understand and agree to abide by any restrictions placed on my participation in camp activities.       Date         Signature of minor or adult camper/staffer       Date         Signature of minor or adult camper/staffer       Date         Date       Date         Signature of minor or adult camper/staffer       Date         Signature of minor or adult camper/staffer       Date         Signature of minor or adult camper/staffer       Date	1	and complete as far as I know. The person nerent document					
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medical treatment including ordening X-rays or treatment, out of camp.         agree to the release of any records necessary for treatment, out of camp.         Signature of parent/guardian or adult camper/staffer		I hereby give permission to the carrie to provide the mergency	administer treatment	moleted form ma	ay be photoco	pied for trips	
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Signature of parent/guardian or adult camper/stamer		acree to the release of any records necessary	25. 13				
Printed Name		Signature of parent/guardian or adult camper/staffer	and a second		Date		
I also understand and agree to abide by any restrictions placed on my participation in camp activities.         Signature of minor or adult camper/staffer			the second se				
I also understand and agree to abide by any restrictions placed on my participation in camp activities. Date							
I also understand and agree to abide by any restrictions placed on my participation in camp activities		1 20 5 G ( 10 C)			· · · · · ·		
Signature of minor or adult camper/staffer							
Signature of minor or adult camper/staffer	1	and agree to abide by any restrictions placed	d on my participation i	n camp activities			
for a local waiver which must be signed for attendance.		also Understand and agree to an arrive for			_ Date		
for a local waiver which must be signed for attendance.		Signature of minor or adult camper/station					
*If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance. *If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance. Convright 1983 by American Camping Association, Inc. Revised 1990, 1992, 1994, 1995, 1996, 1998, 1999, 2000, 2001.							
*If for religious reasons you cannot sign this, contact the camp to the part of the second to the se	I	this contact the cam	o for a legal waiver v	which must be	signed för al	tendance.	
Copyright 1983 by American Camping Association, Inc. Revised 1930, 1932, 1904, 1981	me	*If for religious reasons you cannot sign this, contact the carry	icad 1000 1002 100	4, 1995, 1996,	1998, 1999	, 2000, 2001.	
	a	Convright 1983 by American Camping Association, Inc. Revi	1360 1330, 1332, 133			ñ	

## Health History

The following information must be filled in by the parent guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to *provide appropriate* care. Keep a *copy of* the

Completed *form* for *your* records. Any changes to this *form* Should be provided to camp health personnel upon Participant's *arrival* in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES list all known. Describe reaction and management of the reaction.

Medication allergies (list)

Food allergies (List)

Other allergies (List) - Include insect stings, hay fever, asthma, animal dander, etc.

\_ \_

## MEDICATIONS BEING TAKEN

Please list ALL medications (Including over-the-counter or packaging/bottle that identifies the prescribing physician (if a nonprescription drugs) taken routinely. Bring enough prescription drug), the name of the medication, the dosage, medication to fast the entire time at camp. Keep it in the original and the frequency of administration.

O This person takes NO medications on a routine basis.

This person takes medications as follo	ws:
Med #1	Dosage'Specific times taken each day — — — — — —
Med #2 — — — — — Reason for taking	Dosage Specific times taken each day
Reason for taking ————– Attach additional pa -for more medica	

## RESTRICTIONS

The following restrictions apply to this individual. Dietary 0 Does not eat red meat O Does not eat pork D Does not eat poultry O Does not eat seafood 

O Does not eat eggs 0 Does not eat dairy products

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary )

attendance India	Individual on		irements specify exams within 24 months <i>of</i> cam is not necessarily required for camp attendance.)
BP	Weight	Height — — –	
In my opinion, the	-	is not able to partcipate in an ad	
applicant is under	the care of a physician for	the following conditions	
	ions and Restricons a	at Camp	
Treatment to be con	ntinued at camp		
Medications to be ad	dministered at camp (name,	, dosage, frequency)	
Any medically-prescr	ribed meal plan or <i>dietary</i> r	restrictions	
Known <i>allergies</i>			
Description of any lim	nitation <i>or</i> restriction on carr	np activities	
		·	
dditional Information	for health care staff at the	camp	
		camp	
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General Questions (Explain "yes" answers below.)

Has/does the participant:	Yes	s No
1. Had any recent injury, illness or infectious		
disease?	0	С
2. Have a chronic or recurring illness/condition?	0	0
3. Ever been hospitalized?	Ο	0
4. Ever had surgery?	0	0
5. Have frequent headaches?	0	0
6. Ever had a head injury?	0	0
7. Ever been knocked unconscious?	0	0
8. Wear glasses, contacts or protective		
eye wear?	0	0
9. Ever had frequent ear infections?	Ο	0
10. Ever passed out during or after exercise?	0	0
11. Ever been dizzy during or after exercise?	0	0
12. Ever had seizures?	0	0
13. Ever had chest pain during or after exercise?	0	0
14. Ever had high blood pressure?	0	
15. Ever been diagnosed with a heart murmur? 0	D	
16. Ever had back problems?	D	
-		

10		Ye	s No
	17. Ever had problems with joints		
0	{e.g., knees, ankles)?	0	0
С	18. Have an orthodontic appliance being		0
С	brought to camp?	0	0
)	19. Have any skin problems (e.g., itching,		Ŭ
)	rash, acne)?	0	0
)	20. Have dabetes?	0	Õ
)	21. Have asthma?	Õ	õ
	22. Had mononucleosis in the past 12 months?	õ	0
	23. Had problems <i>with</i> diarrhea/constipation?	ŏ	0
)	24. Have problems with sleepwalking?	0	0
	25. If female, have an abnormal menstrual	0	0
	history?	П	0
	26. Have a history of bed-wetting?		0
			0
	<ul><li>27. Ever had an eating disorder?</li><li>28. Ever had emotional difficulties for which</li></ul>	0	0
	professional help was sought? (	)	0

Please explain *any* "yes" answers, noting the number of the questions.

Which of the following Please give all dates *of* immunization for: Vaccine: Dates: Mo/Yr Mo/Yr Mo/Yr has the participant had? Mo/Yr Mo/Yr Mo/Yr 0 Measles DTP 0 Chicken pox TO (tetanus/diphtheria) 0 German measles Tetanus 0 Mumps Polio D Hepatitis A MMR D Hepatitis B. =- or Measles o Hepatitis c ·· *or* Mumps Ż . . or Rubella Haemophilus influenza 8 **TB Mantoux Test** Hepatitis B Date of last test-----'---Result: 0 Positive 0 Negative Varicella (chicken pox)

\_\_\_\_\_:\_\_\_Phone\_\_\_\_

Use this space to provide *any* additional hformation about the participant's behavior and physical emotional, or mental health about which the camp should be aware.-

 Name of family physician
 Phone

Address'
 \_\_\_\_\_\_\_

Name of family dentist/orthodontist

Address ----- ------