

CAMP BOURNE DALE HEALTH FORM

Dates of camp attendance _____ to _____.

The following Health Information is to be filled out by parents/guardians/doctors of minor or by adults themselves.

Name _____ Birthdate _____ Age at camp _____
Last first middle

Home Address _____
Street city state zip

Social Security Number _____

Custodial Parent/guardian _____ Phone _____

Home address _____
(If different) Street city state zip

Business address _____ Phone _____
Street city state zip

Second Parent or Guardian _____

Address _____ Phone _____

Business address _____ Phone _____

If not available in emergency notify _____

Address _____ Phone _____

Insurance Information – Please fill out completely

Is the participant covered by family medical/hospital insurance? _____ Yes _____ No

Carrier of plan name _____ Group# _____

Carrier Address _____

Name of insured _____ Relationship to insured _____

Social Security number of policy holder or insurance ID number _____

Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I can not 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 the person named above.

Signature of parent/guardian or adult staff- _____

Witness _____ Date _____

General Questions(Explain yes answers below)

Has/does the participant:	YES	NO	YES	NO
1.Had a recent injury, illness Or infectious disease	_____	_____	_____	_____
2. Ever Been hospitalized?	_____	_____	10. Had high blood pressure?	_____
3. Ever had surgery?	_____	_____	11. Have a heart murmur?	_____
4. Ever had a head injury?	_____	_____	12. Any skin problems?	_____
5. Been knocked unconscious?	_____	_____	13. Any Back problems?	_____
6. Wear glasses or contacts?	_____	_____	14. Have Diabetes?	_____
7. Have frequent ear infections?	_____	_____	15. Have Asthma?	_____
8. Ever had seizures?	_____	_____	16. History of bed-wetting?	_____
9. Ever had chest pains?	_____	_____	17. Had an eating disorder	_____
			18. Had emotional problems for which professional help was sought?	_____

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

Which of the following has the participant had?

_____Measles _____Chicken Pox _____German Measles _____Mumps _____Hepatitis

Please give dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____
TD(tetanus/Diphtheria)		_____	_____	_____	_____
Tetanus		_____	_____	_____	_____
Polio		_____	_____	_____	_____
MMR		_____	_____	_____	_____
Or measles		_____	_____	_____	_____
Or mumps		_____	_____	_____	_____
Or Rubella		_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____
Vaicella (Chicken pox)		_____	_____	_____	_____
BCG		_____	_____	_____	_____

Please use this space to provide any additional information about the participants behavior and Physical, emotional or mental health about which Camp Bournedale should be aware.

Name of Family physician _____ Phone _____
 Address _____
 Name of family
 dentist/orthodontist _____ Phone _____
 Address _____

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

Signed _____ **Printed name** _____ **Date** _____

I also understand and agree to abide by the restrictions place upon my camp activities.

Signature of minor or adult staff _____ **Date** _____

Health History

The following information must be filled out by the parent/guardian or adult staff. Please provide complete information so Camp can be aware of your needs.

MEDICATIONS TAKEN:

List all medications taken routinely (including over the counter drugs). Supply nurse with enough medications to last the entire camp stay. Keep medications in original bottle/package that identifies the prescribing physician's name of medication, dosage and the frequency of administration.

This person takes no medication on a routine basis. _____yes

This person takes the following medications:

Med. #1 _____ Dosage _____ Specific times taken each day _____
Reason for Med. _____

Med. #2 _____ Dosage _____ Specific times taken each day _____
Reason for Med. _____

Attach additional pages for more medications

Identify any medications taken during the school year that participant does not take during the summer: _____

Permission For the Administration of Medication- I hereby give permission for the camp nurse to administer these, and those medications prescribed by the camp Physician, for my child. I will be notified by Camp nurse of any prescription medicine prescribed by the camp physician.

Signature of Parent/Guardian _____
(Parent/Guardian must sign here for Nurse to be able to administer over the counter medications)

ALLERGIES

List all known and describe reaction and treatment of reaction.

Medication allergies (list)

Food Allergies (list)

Other Allergies (list) – including hayfever, asthma, insect bites, bee stings, etc.

DIETARY

The participant does not eat the following:

_____ red meat _____ poultry _____ pork _____ seafood _____ eggs _____ dairy products

other foods _____

RESTRICTONS TO ACTIVITY

Explain what participant cannot do or what limitations are necessary_____

Health Care Recommendation by Licensed Medical Personnel

I have examined the above camp participant. Date of last examination_____
In my opinion, the above applicant_____is_____is not able to participate in the active camp program.

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

Current treatment at this time of report includes:

Recommendations and Restrictions at Camp Bournedale

Treatment to be continued at camp:_____

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

Any medically-described meal plan or dietary restrictions_____

Known allergies:_____

Description of any limitations or restrictions on camp activities_____

Additional Information_____

Signature of Licensed Medical Personnel_____

Printed_____ **Title**_____ **Date**_____

Address_____ **Phone**_____

For Camp Bournedale use only Screening Record

Date screened_____ Time_____

Medications received_____

Updates/additions to health history noted:_____Yes_____No_____none required

Current health needs identified:_____

Observational notes:_____

Screened by:_____