HEALTH HISTORY AND EXAMINATION FORM FOR STAFF ATTENDING CAMP

The information on this form is not part of the staff acceptance process, but is gathered to assist us in identifying appropriate care. Please understand, the more information we have the better able we are to ensure a safe and healthy summer. This form, except for the "Health Recommendations of Licensed Medical Personnel", is to be filled in by parents/guardians of minors or by staff over 19 years old.

Name Last ____ **First** ____ **Middle Initial** ___________

Home Address: # & Street ____ **City** ____

State _________________ **Zip/Postal Code** ___________________ **Country** ____

Participant Social Security Number (US staff) __________________ Male ______ Female _______ Birth Date _____________________ Age ____________

Custodial Parent/Guardian ______________________________________	**Custodial Parent/Guardian** ______________________________________
Home Phone ____________________ **Work Phone** ________________	**Home Phone** ____________________ **Work Phone** ________________
Cell/Mobile Phone _____________________________________	**Cell/Mobile Phone** _____________________________________
Home Address Street ____	**Home Address** Street ____
City _________________________________ State _________________	City _________________________________ State _________________
Zip/Postal Code ______________ Country _______________________	Zip/Postal Code ______________ Country _______________________

EMERGENCY CONTACT INFORMATION If Parent(s)/Guardian(s) are not available in an emergency, please contact:

Name ____ **Relationship** _____________________________________

Home Phone ____ **Work Phone** _____________________________________

Cell/Mobile Phone ____

INSURANCE INFORMATION (If travel insurance plan, please indicate and give details)

Is the Participant covered by family medical/hospital insurance? Yes________ **No**________

If so, indicate carrier/plan name _____________________________**Group #**____________________ **Policy #** _________________

Carrier Address ____

Claims/Phone Authorization # _____________________________________ **Co-Pay Amount** _______________________________

Name of Insured ____ **Relationship to Participant** ___________________________

_ _

PRESCRIPTION/MEDICATION PLAN INFORMATION (if applicable)

Name of Insured __________________________________ **Insured SS#** ____________________ **Relationship** _________________

Company Name __________________________________ **Group #** _______________________ **Policy #** _____________________

Prescription Information # ___________________________________ **Co-Pay Amount:** Generic ___________ Brand ____________

A COPY OF FRONT AND BACK OF YOUR INSURANCE AND PRESCRIPTION ID CARD/S MUST BE ATTACHED TO THIS FORM!

IMPORTANT- THIS BOX MUST BE COMPLETE FOR ATTENDANCE

PARENT/GUARDIAN/STAFF OVER 19 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. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me. In the event that I cannot be reached in an emergency, I hereby give permission to the physician/health care provider selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature ____________________________________ Printed Name ______________________________________ Date ______________________

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature ____________________________________ Date ________________________

HEALTH HISTORY

The following information must be filled in by the parent/guardian, or adult camper or staff member (over 19). 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.

It is our experience that more and more people are availing themselves of the service of psychiatrists, psychologists, social workers, and counselors to deal with a variety of complex issues and emotional difficulties. The policy of ACAWE is not to disqualify you with problems provided they can function in a camp environment. It is therefore necessary that a candid description of past, present, and potential difficulties be honestly described for the confidential use of the professional staff, to enable us to intelligently and sensitively work with your child should any problems arise**.**

ALLERGIES ***Please describe reaction and management of the reaction.***
MEDICATION ALLERGIES

___ Penicillin ____

___ Amoxicillin ____

___ Septra ____

___ Aspirin ____

___ Erythromycin ____

___ Sulpha ____

___ Other ____

FOOD ALLERGIES

___ Nuts ____

___ Shellfish ____

___ Eggs ____

___ Other ____

OTHER ALLERGIES

___ Hay Fever ____

___ Ivy Poisoning ____

___ Bee Stings ____

___ Insect Stings ____

___ Other ____

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

___ This person 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 ____

Attach additional pages for more medications or information about side effects. Identify any medications taken during the school year that participant does/may take during the summer:
____

I give permission to the Camp Health Personnel to dispense any medications as needed. ____ Yes ____ No

RESTRICTIONS
Dietary

___ Does not eat red meat ___ Does not eat fish ___ Does not eat eggs ___ Does not eat poultry ___ Does not eat dairy

___ Other (describe) ____

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

____

____

GENERAL QUESTIONS – Explain "yes" answers below

Has/does the participant:

#	Question	YES	NO
1.	Had any recent injury, illness, or infectious disease?	___	___
2.	Have a chronic or recurring illness/condition?	___	___
3.	Ever been hospitalized?	___	___
4.	Ever had surgery?	___	___
5.	Have frequent headaches?	___	___
6.	Ever had a head injury?	___	___
7.	Ever been knocked unconscious?	___	___
8.	Wear glasses, contacts, or protective eyewear?	___	___
9.	Ever had frequent ear infections?	___	___
10.	Ever passed out during or after exercise?	___	___
11.	Ever been dizzy during or after exercise?	___	___
12.	Ever had seizures/convulsions?	___	___
13.	Ever had chest pain during or after exercise?	___	___
14.	Ever been diagnosed with a heart murmur?	___	___
15.	Ever been diagnosed wit high blood pressure?	___	___
16.	Ever had back problems?	___	___
17.	Ever had epilepsy?	___	___
18.	Ever had treatment for drug/alcohol abuse?	___	___
19.	Have a history of smoking? If so, how many?	___	___
20.	Ever had problems with joints (e.g. knees, ankles)?	___	___
21.	Have an orthodontic appliance brought to camp?	___	___
22.	Have any skin problems (e.g. itching, rash)?	___	___
23.	Have diabetes? (Date of onset)	___	___
24.	Have asthma? (Date of onset)	___	___
25.	Had mononucleosis in the past 12 months?	___	___
26.	Had problems with sleepwalking?	___	___
27.	Have problems with diarrhea/constipation?	___	___
28.	Have a history of bed-wetting?	___	___
29.	Ever had an eating disorder?	___	___
30.	Ever had emotional difficulties for which professional help was sought?	___	___
31.	Ever been diagnosed with ADD/ADHD?	___	___

Please explain any "yes" answers, noting the number of the question being addressed.

____

____

____

HEALTH HISTORY

Which of the following has the participant had?

___ Measles

___ Chicken Pox

___ German Measles

___ Mumps

___ Hepatitis A

___ Hepatitis B

___ Hepatitis C

___ Rheumatic Fever

IMMUNIZATION HISTORY – WITH DATES

This is a record of ***DATES*** of basic immunization and booster doses

___ DPT ____

___ Polio OPV (Sabin) ___________________________________

___ MMR ____

___ or measles ________________________________

___ or Mumps _________________________________

___ or Rubella ________________________________

___ Smallpox ____

___ Tetanus Booster ______________________________________

___ Hepatitis B ____

___ TB Mantoux Test- Date of last test ____________ Result: _____

___ Other ____

IMPORTANT – THIS BOX MUST BE COMPLETE FOR ATTENDANCE

Parent/Guardian/Staff Member over 19 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 as noted.

Signature ____ Printed ____

Date ________________________________

Disclosure of Medical Information

I understand that the Camp is not defined as an entity subject to HIPAA (Health Information Privacy)**** and therefore is not covered by HIPAA regulations concerning the patient medical records. I also understand and agree that situations may necessitate that medical information be shared with the administrative staff, the camp doctors and nurses and the faculty. I give permission to any Health Care Provider, such as a hospital or physician to share my medical information with the Camp doctors and nurses and other Camp medical staff, for treatment purposes.

Signature ____ Printed ____

Date ________________________________

*** For more information visit http://www.hhs.gov/ocr/hipaa/

MEDICAL EXAMINATION – *To be completed and signed by a licensed physician*
This examination should be performed within twelve months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Code: S= Satisfactory X= Not Satisfactory (explain) O= Not Examined * if applicable

Hgt _______ Wt ________ Hgb Test ________ Urinalysis ________ Eyes ________ Glasses/Contacts _________

Ears ________ Nose ________ Throat ________ Teeth ________ Heart ________ Lung ________

Extremities ________ Posture (spine) ________ Skin ________ Hernia ________

For FEMALE – Has this person menstruated? _________ If not, has she been told about it? ________

If so, is her menstrual history normal? ________

Known allergies ____

General Appraisal ____

Special Considerations ____

RECOMMENDATIONS AND RESTRICTIONS

Special medicine or injections – please specify ____

____

Medications discontinued prior to summer. If so, why? ____

Swimming, diving, and/or strenuous activity? _______________________________ Exposure to the sun and heat? _____________________

Other ____

Is there any congenital malformation now existing that may require special treatment or consideration? ______________________________

If yes, please explain? ____

Is there any history of emotional disturbance in the applicant? ____

Has she/he shown any:

Difficulties in the relationship with parents, authority figures, persons of his/her own age? ________________________________

Behavioral disorders? ____

Emotional symptoms such as mood swings, depression, sleep disorders, unusual degree of anxiety, fear or guilt? ____________

Please explain ____

Has the applicant been to a psychiatrist within the last 4 years? ____

Has this applicant been involved in psychological therapy? ____

To your knowledge, is there any history of drug/alcohol related problems? ____________________________________

If yes, please explain ____

Does this person smoke cigarettes? ______________________________________ If yes, how many a day? __________________________

I have examined this individual and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities except as noted above. I have been this applicant's physician for _____ years.

Examining Physician ____ Printed ____ Date ___________

Address____

Telephone number ____

FOR ACAWE USE ONLY

Date Received ________________________________ Date Reviewed ____________________________________

FOR CAMP USE

Date Received ________________________________ Date Reviewed ____________________________________

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