

Please check one: CAMPER or STAFF

2009 Camping Season

Health History and Examination Form

Dates of Camp Attendance _____

Full Session June 20 - August 13
 1st Session June 20 - July 19
 2nd Session July 21 - August 13
 TR-12 June 20 - July 1
 July 1- July 12
 July 21- August 1

Mail this form to:
 Timber Ridge Camp
 10400 Stevenson Rd. Suite 201
 P.O. Box 349
 Stevenson, MD 21153
June 1, 2009

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. This form, except for the insert "Health Recommendations of Licensed Medical Personnel", is to be filled in by parents/guardians of minors or by adults themselves.

Name _____ Birth Date _____ Age at camp _____
 Last First Middle

Home Address _____
 Street address City State Zip Code

Home Phone Number _____
 (area code)

Mother's Cell Number _____ Father's Cell Number _____

Social security number of participant _ _ _ - _ _ - _ _ _ _

Gender: Male Female

Custodial parent/guardian _____ Phone _____

Home Address _____
 (If different from above) Street address City State Zip Code

Second parent or guardian or emergency contact _____

Address: _____ Phone _____

*****IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY:**

Name _____ Relationship _____

Phone _____ Address _____

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance?

YES NO

If so, indicate carrier of plan name _____

Name of Insured _____ Relationship to Insured _____

Insurance #: _____ Group #: _____

Insurance Address _____

*****Must be signed:

I hereby authorize you to administer Dramamine for motion sickness if needed.

Yes No Signature _____

*****IMPORTANT: THIS BOX MUST BE COMPLETED FOR ATTENDANCE*****

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 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 the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper _____

Witness _____ Date _____

I also understand and agree to abide by the restrictions placed on my camp activities.

Signature of minor or adult camper/staffer _____ Date _____

*If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Health History

The following information must be 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 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 medication on a routine basis.

This person takes medications as follows:

Medicine # 1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Medicine #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications.

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

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

- 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) _____

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:	YES	NO		YES	NO
1. Had any recent injury, illness or Infectious disease? -----	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints-----	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?-----	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?-----	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?-----	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g. itching, rash, acne?)-----	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?-----	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?-----	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?-----	<input type="checkbox"/>	<input type="checkbox"/>	21. Have Asthma?-----	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?-----	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?-----	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious? -----	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?-----	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear-----	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?---	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?-----	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?-----	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?--	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?-----	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?--	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?-----	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures? -----	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?-----	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?-----	<input type="checkbox"/>	<input type="checkbox"/>			
14. Ever had high blood pressure? -----	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?--	<input type="checkbox"/>	<input type="checkbox"/>			
16. Ever had back problems? -----	<input type="checkbox"/>	<input type="checkbox"/>			

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

Use this space to provide any additional information 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 _____ 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 _____ Date _____

HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

PATIENT'S NAME _____

I have examined the above 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:
Treatment to be continued at camp

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

Any medically prescribed meal plan or dietary restrictions

Known allergies

Description of any limitation or restriction on camp activities

Additional information for health care staff at the camp

MUST HAVE THIS INFORMATION!!!!

Which of the following has the participant had?

- Measles
- Chicken pox
- German Measles
- Mumps
- Hepatitis
-

____ Date of last TB Mantoux test
Result _____

VERY IMPORTANT!!!!

Please give date for last immunization for:

<u>Date</u>	<u>Vaccine</u>
_____	DTP
_____	TD (tetanus/diphtheria)
_____	Tetanus
_____	Polio
_____	Measles (hard or red measles or rubella)
_____	Rubella
_____	Haemophilus influenza B
_____	Hepatitis B
_____	Varicella Zoster

SIGNATURE OF LICENSED MEDICAL PERSONNEL

Printed _____ Title _____
Address _____ Phone () _____
Date _____

For Camp Use Only:

Screening Record

Date screened _____ am
Time _____ pm

Meds received _____

Updates/additions to health history noted Yes No None required

Current health needs identified:

Observational notes:

Screened by _____