

# Health History and Examination Form for Children, Youth and Adults

Dates of Camp Attendance \_\_\_\_\_

## Attending Camps **FM08N**

**Suggested for resident camp use.**

Developed and approved by American Camp Association with the American Academy of Pediatrics

Mail this form to the address below by \_\_\_\_\_ (date):

**Cazadero Performing Arts Camp  
P.O. Box 7908  
Berkeley, CA 94707**

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. Health history (first three pages) must be filled out by parents/guardians of minors or by adults themselves. Update required annually. Health exam (back page) must be completed by approved licensed medical personnel at least every two years.

Year: \_\_\_\_\_

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_  
Last First Middle

Home address \_\_\_\_\_  
Street Address City State Zip

Social Security Number of participant \_\_\_\_\_ Gender:  Male  Female

**Custodial parent/guardian** \_\_\_\_\_ Phone \_\_\_\_\_

Home address \_\_\_\_\_  
(if different from above) Street Address City State Zip

Business address \_\_\_\_\_  
Street Address City State Zip Phone \_\_\_\_\_

**Second parent or guardian or emergency contact** \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address City State Zip

Business address \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address City State Zip

**If not available in an emergency, notify** \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

### Insurance information

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

If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

**Photocopy of front and back of health insurance card must be attached to this form.**

### Important — These boxes must be completed for attendance\*

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, seek and consent to routine health care, administration of prescribed medications and emergency treatment for me/my child, as may be necessary, including but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting in loco parentis if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as

“personal representatives” for the purpose of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR & 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person’s ability to participate in camp activities; and (ii) in the case of minors to provide relevant information to the camp representatives to keep me informed of my child’s health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician 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 of parent/guardian or adult camper/staffer \_\_\_\_\_

Printed Name \_\_\_\_\_ 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 \_\_\_\_\_

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

Cabin or Group: \_\_\_\_\_

Name: \_\_\_\_\_

## 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 nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep 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.

<input type="checkbox"/> This person takes NO medication on a routine basis
---

<input type="checkbox"/> 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.		
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

<input type="checkbox"/> Does not eat red meat	<input type="checkbox"/> Does not eat pork	<input type="checkbox"/> Does not eat eggs
<input type="checkbox"/> Does not eat poultry	<input type="checkbox"/> Does not eat seafood	<input type="checkbox"/> Does not eat dairy products
<input type="checkbox"/> 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 (e.g., knees, ankles)?	<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.**

---



---



---



---

Which of the following has the participant had?

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test

Date of last test \_\_\_\_\_

Result:  Positive  Negative

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	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		_____	_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

**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 \_\_\_\_\_

## Health Care Recommendations by Licensed Medical Personnel

I examined this individual on \_\_\_\_\_. (ACA accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

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

---

---

---

---

## 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

---

---

**Signature of licensed medical personnel** \_\_\_\_\_

Printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

## For camp use only

### Screening record

Date screened \_\_\_\_\_ Time \_\_\_\_\_ am

Meds received \_\_\_\_\_ pm

Updates/additions to health history noted  Yes  No  None required

Current health needs identified \_\_\_\_\_

Observational notes \_\_\_\_\_

Screened by \_\_\_\_\_