CAMP HEALTH HISTORY AND EXAMINATION FORM

Haycock Camping Ministries

Name: _____
Camp Name: _____
Session: _____
Program: _____
Keep a copy of this form for your own records

Name: _____

Date of Birth: _____ Age: _____

PARENT/GUARDIAN #1

Name: _____ Relationship: _____
Phone #1: _____
Phone #2: _____
Address: _____
City: _____
State/Province: _____ Zip/Postal Code: _____

PARENT/GUARDIAN #2

Name: _____
Relationship: _____
Phone #1:
Phone #2:
Address: _____
City: _____
State/Province: _____ Zip/Postal Code:

EMERGENCY CONTACT

Name: _____ Relationship: _____
Phone #1: _____
Phone #2: _____
Phone #3: _____
Address: _____
City: _____
State/Province: _____ Zip/Postal Code: _____

Health Care Providers

Primary: _____ Phone: _____
Dentist: _____ Phone: _____
Orthodontist: _____ Phone: _____

Insurance Information

Covered by medical/hospital insurance? ☐ Yes ☐ No
Insurance Company: _____
Policy Number: _____ Group/ID: _____
Name of Insured: _____ Relationship:
Address: _____
City: _____
State/Province: _____ Zip/Postal Code: _____

Immunization History

Are all immunization up-to-date? ☐ Yes ☐ No

☐ Immunizations are recorded below, with dates that basic immunizations were completed as well as dates of most recent booster doses
☐ School immunization form is attached

	Primary Series	Last Booster		Primary Series	Last Booster
DTaP			MMR		
DPT			Measles		
DT			Mumps		
TDAP			Rubella		
TD					
			Varicella		
Hepatitis B			HIB		
Hepatitis A			PVC		
OPV, IPV (Polio)					

Tuberculosis Screening TST: Last Date _____ Result _____

If immunizations are not up to date, including the DPT, please submit a state certificate from physician or parent stating medical or religious reason. If your child is under 5 years old and is not currently in school full time, please attach a copy of their immunization record.

Allergies

☐ No Known Allergies ☐ Drug ☐ Food ☐ Contact/Environment

_____
_____
_____
_____
_____

Dietary Restrictions

Please specify any accommodations needed.

☐ Vegetarian ☐ Vegan ☐ Kosher ☐ Halal ☐ Allergy ☐ Other

_____
_____

Health History

Check "Yes" or "No" for each statement. Explain "Yes" answers below and explain any accommodations needed.

1. Asthma? ☐ Yes ☐ No
2. Diabetes? ☐ Yes ☐ No
3. Seizures/epilepsy/convulsions? ☐ Yes ☐ No
4. Frequent ear infections? ☐ Yes ☐ No
5. Frequent colds/sore throat? ☐ Yes ☐ No
6. Sinusitis? ☐ Yes ☐ No
7. Bronchitis ☐ Yes ☐ No
8. Fainting/dizziness? ☐ Yes ☐ No
9. Stomach upsets? ☐ Yes ☐ No
10. Constipation/diarrhea? ☐ Yes ☐ No
11. Bed wetting? ☐ Yes ☐ No
12. Sleeping disorder/sleep walking? ☐ Yes ☐ No
13. Urinary tract infections? ☐ Yes ☐ No
14. Heart defect/disease? ☐ Yes ☐ No
15. Bleeding/clotting disorders? ☐ Yes ☐ No
16. Hypertension ☐ Yes ☐ No
17. Recent infectious disease? ☐ Yes ☐ No
18. Chronic/recurring illness? ☐ Yes ☐ No
19. Skin conditions? ☐ Yes ☐ No
20. ADD/ADHD? ☐ Yes ☐ No
21. Emotional disability? ☐ Yes ☐ No
22 Learning disability? ☐ Yes ☐ No
23. Physical disability? ☐ Yes ☐ No
24. Visual disability? ☐ Yes ☐ No
25. Deaf/hard of hearing? ☐ Yes ☐ No
26. Behavioral problems? ☐ Yes ☐ No
27. Psychiatric counseling/hospitalizations? ☐ Yes ☐ No
28. Eating disorder? ☐ Yes ☐ No
29. Has this person menstruated? ☐ Yes ☐ No
30. If not, has she been told about it? ☐ Yes ☐ No
31. If so, is her menstrual history normal? ☐ Yes ☐ No
32. Operations or serious injuries? ☐ Yes ☐ No
33. Other diseases? ☐ Yes ☐ No

_____
_____
_____

AUTHORIZATION

This health history is correct so far as I know. The person herein described has my 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, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. 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.

Name _____ Relationship to Camper _____ Signature _____ Date _____

*If for religious reasons you can not sign this form, then submit a legal waiver which must be signed for attendance

HEALTH EXAMINATION BY LICENSED PHYSICIAN

Haycock Camping Ministries

Please have your child's primary healthcare provider complete this form for you to bring to camp on registration day. You may also fax it to us at:
610-346-8927

Name: _____ Camp Name: _____
Date of Birth: _____ Session: _____
Age: _____ Program: _____

This part to be completed by Physician. ***Must be signed for participation.*** *Please use additional sheet of paper if needed.*

I have examined the above camper within the past year. Date of Examination: _____
In my opinion, the above's conditions ☐ **DOES** / ☐ **DOES NOT** preclude her participation in an active camp program.

Physical Exam Height: _____ Weight: _____ Blood Pressure: _____

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

Current treatment(s) and/or medications(s): _____

Explanation of any reported loss of consciousness, convulsion, or concussion: _____

Does camper have epilepsy or seizures? ☐ YES / ☐ NO If yes, explain: _____

Will the camper need to bring an Epi-Pen? ☐ YES / ☐ NO If yes, explain:

Will the camper need to bring an asthma inhaler? ☐YES / ☐NO If yes, explain :

Any other condition(s) that camp nurse or staff should be made aware? ☐ YES / ☐ NO If yes, explain: _____

Recommendations and/or restrictions while at camp? List any treatment to be continued at camp: _____

Any medically prescribed meal plan or dietary restrictions? _____

Additional information or activity restrictions? _____

Address: _____ City: _____
State: _____ Zip Code: _____ Phone: _____

_____ _____
Name of Licensed Physician Licensed Physician's Signature

Date Form Completed: _____ By _____
(*Initial if completed by nurse or physician's assistant)

MEDICATIONS/TREATMENT TO BE ADMINISTERED AT CAMP

Haycock Camping Ministries

Please have your child's primary healthcare provider complete this form and fax it to
610-346-8927
You may also just bring form to registration day

Name: _____ Camp Name: _____

Date of Birth: _____ Session: _____

Age: _____ Program: _____

1. **By law all prescription medications must be brought to camp in their original containers, with the doctor's instructions. DO NOT pre-dispense, place in a daily pill holder, wrap in outer materials, or ask us to dispense by other than doctor's orders. Do not bring expired medications. Medications not in original containers will not be held or dispensed at camp.**
2. **A parent/guardian must sign this form authorizing any prescription and over-the-counter medications listed below.**
3. **All prescription medicines must be in original container with pharmacy label with prescription number, date filled, prescribing physician's name, name of medication, directions for use, and the patient's name. All Over-the-Counter medications must be in original container should have the campers name written on the box.**
4. **At least one dose of a prescription medicine MUST be given to camper at home before bringing to camp.**
5. **Medicines will be given at breakfast, lunch, dinner and at bedtime, unless noted otherwise.**
6. **Please indicate if medicine is taken daily or as needed.**
7. **You must be specific with any variations or conditions associated with "as needed".**
8. **If your son/daughter will need to bring an inhaler, Epi-Pen, or other emergency medication to camp, please speak to the camp nurse.**

The Health Center stocks the following over-the-counter medication at camp which are used on an as needed basis to manage illness and injury.
Please cross out those the camper should NOT be given.

- ☐ Acetaminophen (i.e. Tylenol)
- ☐ Ibuprofen (i e Advil, Motrin)
- ☐ Diphenhydramine antihistamine/allergy medicine (i.e Benadryl)
- ☐ Cepacol Sore Throat Spray
- ☐ Mucinex plain
- ☐ Guaifenesin cough syrup (i e Robitussin plain)
- ☐ Saline nose drops
- ☐ Antibiotic cream (i.e Bacitracin)
- ☐ Anti-fungal cream (i.e. Tinactin)
- ☐ Absorbine Jr aspirin free analgesic ointment
- ☐ Calamine/Caladryl Lotion
- ☐ 0.5% hydrocortisone cream
- ☐ Medicaine Swabs
- ☐ Anbesol Gel
- ☐ Tums / Chewable Pepto Bismal Tablets

Parent/Guardian Signature: _____ Date: _____

Physician's Address: _____ Phone: _____

City: _____

State: _____ Zip Code: _____

INSURANCE INFORMATION

Haycock Camping Ministries

Please attach a copy of the FRONT and BACK of your insurance card to this form and bring it to camp on Registration Day

Name: _____

Date of Birth : _____

Age: _____

Camp Name: _____

Session: _____

Program: _____

FRONT OF INSURANCE CARD

BACK OF INSURANCE CARD

HAYCOCK
CAMPING MINISTRIES

Medication Permission Form

All medication to be administered by the camp nurse must be delivered by an adult to the camp nurse during registration. Medication must be in the original, properly labeled container. All medications (prescription, over the counter and supplements) to be administered at camp must have a signed parental permission **AND** a signed physician permission. **No medication (prescription, over the counter or supplements) will be administered to any camper without proper completion of the Medication Permission Form.** Campers are not permitted to carry any medication with them. ***Exception-Properly labeled inhalers and Epi-pens with physician permission and completion of Camper Self-Administration Agreement Form.**

TO BE COMPLETED BY PHYSICIAN

Campers Name: _____ Age: _____ DOB: _____

Name of Medication: _____

Specific Dosage: _____ Frequency: _____

Special Considerations: _____

Reason for Medication: _____

Epi-pen/Inhaler: Does camper have permission to self-carry and administer? _____

(Parents: if marked "yes" you must complete the self-administration agreement)

It is my understanding that the camp nurse of Haycock Camping Ministries charged with administration of the treatment/procedure during camp rely on the directions contained in this document. I further certify that I am the physician who prescribed the medication/treatment and that the camper named above is under my supervision as a patient.

Signature of Physician: _____

Printed Name of Physician: _____

Address: _____

Telephone: _____ Fax: _____ Date: _____

To BE COMPLETED BY PARENT/GUARDIAN: As parent/guardian of the above named student, I hereby request that the treatment described above be administered to my child and release Haycock camping Ministries and its staff/volunteers from liability for any damages my child may suffer as a result of this request.

Signature of Parent of Guardian: _____ Date: _____

Camper Name: _____ Session: _____

Pre-Camp Health Screening

Dear Camp families,

In an effort to minimize illness at camp we ask that you check on the health of your camper daily beginning 14 days prior to camp. The best camp sessions start with healthy campers and this begins at home. Please bring this completed form to camp on opening day.

Please indicate if your camper has any of the following symptoms prior to camp and record a temperature daily. If any temperature or symptoms are present, please have your camper evaluated by a licensed provider and contact camp for further guidance.

Symptoms (symp):

- Cough
- Shortness of breath or difficulty breathing
- Fever
- Chills
- Muscle Pain
- Sore throat
- New loss of taste or smell
- Nausea
- Vomiting
- Diarrhea

Please initial

1. My child has not been around anyone with any of the listed symptoms or diagnosis of COVID19 in the 14 days before the start of camp. Initial _____

2. No one in our household has been sick in the 14 days prior to camp. Initial _____

3. My child has not traveled by air or traveled out of state in the 14 days prior to camp. Initial _____

4. My child has adhered to our state's guidelines regarding COVID19. Initial _____

Start date of temperature/ symptom screening:

_____

Day:	14	13	12	11	10	9	8
Temp/ symp							
Day:	**7**	**6**	**5**	**4**	**3**	**2**	**1**
Temp/ symp							

Our signature indicates that we completed this health screening daily for 14 days prior to camp and to the best of our ability. We understand that arriving to camp healthy is vital to a healthy camp for all campers.

Parent Signature: _____ Date:_____

Camper Signature: _____ Date:_____

created by Eleanor Matthews, RN 2020