

**Health History and Examination Form  
for Children, Youth and Adults  
Attending Camps** FM 08

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

Mail this form to the address below by 5/1/2010 (date)

**CAMP NAKANAWA**  
1084 Camp Nakanawa Road  
Crossville, Tennessee 38571-2146  
Fax: 931-277-5552

Developed and approved by  
*American Camping Association*  
American Academy of Pediatrics

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 "Health

Recommendations of a Licensed Medical Personnel," 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

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

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

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

Business address \_\_\_\_\_ Phone \_\_\_\_\_

If not available in an emergency, notify:

Name \_\_\_\_\_

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

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

\*\*\*Please include a photocopy of your Insurance Card, (front and back), and the Social Security Number and Date of Birth of the insured card holder. This is needed in case of an emergency trip to the hospital or doctor's office.

**Insurance Information**

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

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

Carrier address \_\_\_\_\_

Name of insured \_\_\_\_\_ Relationship to participant \_\_\_\_\_

Date of Birth, Social Security Number and Insurance ID Number of Policy Holder \_\_\_\_\_

**IMPORTANT --- THESE BOXES 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/staffer \_\_\_\_\_

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."*

Please check whether you are attending:

(June 13 – June 26) 2 Week Junior \_\_\_\_\_ 2 Week Intermediate \_\_\_\_\_

(June 28 – July 25) 4 Week Junior \_\_\_\_\_ 4 Week Int/Senior \_\_\_\_\_

Year

Cabin or Tent

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 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.

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

## RESTRICTIONS

All special dietary needs must be acknowledged by a licensed Physician with a written request to the camp and then approved by the directors. Supplemental foods will be kept in the Infirmary. Any possible menu substitutions, questions or concerns must be discussed with the directors prior to May 1<sup>st</sup>.

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?  Yes  No
2. Have a chronic or recurring illness/condition?  Yes  No
3. Ever been hospitalized?  Yes  No
4. Ever had surgery?  Yes  No
5. Have frequent headaches?  Yes  No
6. Ever had a head injury?  Yes  No
7. Ever been knocked unconscious?  Yes  No
8. Wear glasses, contacts or protective eye wear?  Yes  No
9. Ever had frequent ear infections?  Yes  No
10. Ever passed out during or after exercise?  Yes  No
11. Ever been dizzy during or after exercise?  Yes  No
12. Ever had seizures?  Yes  No
13. Ever had chest pain during or after exercise?  Yes  No
14. Ever had high blood pressure?  Yes  No
15. Ever been diagnosed with a heart murmur?  Yes  No
16. Ever had back problems?  Yes  No

17. Ever had problems with joints (e.g., knees, ankles)?  Yes  No
18. Have an orthodontic appliance being brought to camp?  Yes  No
19. Have any skin problems (e.g., itching, rash, acne)?  Yes  No
20. Have diabetes?  Yes  No
21. Have asthma?  Yes  No
22. Had mononucleosis in the past 12 months?  Yes  No
23. Had problems with diarrhea/constipation?  Yes  No
24. Have problems with sleepwalking?  Yes  No
25. If female, have an abnormal menstrual history?  Yes  No
26. Have a history of bed-wetting?  Yes  No
27. Have an eating disorder?  Yes  No
28. Ever had emotional difficulties for which professional help was sought?  Yes  No

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

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Which of the following has the participant had?

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis
- Varicella Zoster

\_\_\_\_\_ Date of last TB Mantoux test  
Result \_\_\_\_\_

Please give date for last immunization for:

Date	Vaccine
_____	DTP
_____	TD (tetanus/diphtheria)
_____	Tetanus
_____	Polio
_____	Measles (hard or red measles or rubeola)
_____	Rubella
_____	Haemophilus influenza B
_____	Hepatitis B

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.

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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**

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

\_\_\_\_\_

<b>Signature of Licensed Medical Personnel</b> _____	
Printed _____	Title _____
Address _____	
Phone _____	Date _____

*For camp use only*

<b>Screening Record</b>	
Date screened _____	Time _____ am pm
Meds received _____	
Updates/additions to health history noted <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None required	
Current health needs identified _____	
Observational notes _____	
Screened by _____	