

For Office Use

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

FM 08N

Suggested for resident camp use.

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

Please check whether you are attending:

(June 18 - July 1) 2 Week Junior \_\_\_\_\_ 2 Week Intermediate \_\_\_\_\_  
(July 3 - July 30) 4 Week Junior \_\_\_\_\_ 4 Week Int/Sr \_\_\_\_\_

Mail this form to the address below by 5/15/17 (date)

Camp Nakanawa  
1084 Camp Nakanawa Road  
Crossville TN 38571  
Fax: 931/277-5552

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.

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

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

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

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

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

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

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

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

\*\*\*A photocopy of the front and back of your insurance card **must** be attached to this form. Also provide the Social Security Number and birthdate of the insured card holder. This is needed in case of an emergency trip to the hospital or doctor's office.

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

<p>This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.</p> <p>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.</p> <p>It is my intention that the camp be treated as acting <i>in loco parentis</i> if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal</p>	<p>representatives" for the purposes 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.</p> <p>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.</p>
Signature of parent or 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 reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Year

Cabin or Group

Name

**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.

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Which of the following has the participant had?	Please give all dates of immunization for:
<input type="checkbox"/> Measles	Vaccine: DTP
<input type="checkbox"/> Chicken pox	TD (tetanus/diphtheria)
<input type="checkbox"/> German measles	Tetanus
<input type="checkbox"/> Mumps	Polio
<input type="checkbox"/> Hepatitis A	MMR
<input type="checkbox"/> Hepatitis B	or Measles
<input type="checkbox"/> Hepatitis C	or Mumps
	or Rubella
TB Mantoux Test	Haemophilus influenza B
Date of last test _____	Hepatitis B
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	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.

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Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

## 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 of 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 Commissary. Any possible menu substitutions, questions or concerns must be discussed with the directors prior to May 1st.

#### Dietary

Does not eat red meat

Does not eat pork

Our menus can be found on our website: [www.campnakanawa.com](http://www.campnakanawa.com)

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)

_____
_____
_____

**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*

<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 _____	