CAMP HEALTH HISTORY AND EXAMINATION - 2012

This side to be filled in by parents/guardian of minors **RETURN BY MAY 1ST, 2012**

RETURN TO:
CAMP CAROLINA
PO BOX 919
BREVARD NC 28712

Circle Session Choice **FIRST** **MAIN** **THIRD** **INTRO 1** **INTRO 2** **7WK 1** **7WK 2** **10WK**

Name____ Birth Date ________ Sex _____ Age ______ SS# ______________
last first initial

First Parent or Guardian ____ SS# ____________________D.O.B. __________

Home Address ____ Phone __________________________
and Street city state zip area/number

Business Address ____ Phone __________________________
and Street city state zip area/number

Second Parent or Guardian ____ SS# ______________________D.O.B. _________

Home Address ____ Phone __________________________
and Street city state zip area/number

Business Address ____ Phone __________________________
and Street city state zip area/number

If not available in an emergency, notify:
Name____ Phone __________________________
area/number
Address____
and Street city state zip

Health History (Check – giving approximate dates)

Frequent Ear Infections	___________	Psychiatric Treatment	_____________	***Allergies***	
Heart Defect/Disease	___________	Mononucleosis	_____________	Hay Fever	___________
Convulsions	___________	***Diseases***		Ivy Poisoning Etc.	___________
Diabetes	___________	Chicken Pox	_____________	Insect Stings	___________
Bleeding/Clotting Disorders	___________	Measles	_____________	Penicillin	___________
Hypertension	___________	German Measles	_____________	Other Drugs	___________
		Mumps	_____________	Asthma	___________

Has this camper ever required any psychiatric counseling or hospitalization? ______________________________
Operation or serious injuries *(dates)*: ____
Disability or chronic or recurring illness: ____
Any specific activities to be discouraged or limited by physician's advice:______________________________
____
Dietary modifications: ____
Current medication *(send with instructions)*: ____
Other diseases or details of above:____
Name of dentist/orthodontist: ____ Phone ____________________
Name of family physician: ____ Phone ____________________
Date of last physical examination: ____

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

INSURANCE INFO: Health Insurance is required for your son while attending Camp Carolina

ATTACH A COPY OF YOUR HEALTH AND ACCIDENT INSURANCE CARD (FRONT & BACK) TO THIS HEALTH FORM. DOCTORS AND THE HOSPITAL REQUIRE THIS BEFORE THEY WILL TREAT YOUR SON. IN ADDITION WE REQUIRE A CREDIT CARD TO BE ON FILE TO COVER THE COST OF PRESCRIPTIONS & DOCTOR VISITS.

MC/VISA # (ONLY) ____ **CODE** ________ **EXP DATE** ________

NAME ON CARD ____ **BILLING ZIP CODE**_________________

To the best of my knowledge this health history is correct and the person listed above has permission to engage in all prescribed camp activities except as noted.
I hereby give permission to the camp:
To provide ongoing health care.
To select medical personnel.
To order X-rays or routine tests or treatment for the person listed above..
Release of Records.

Emergency Authorization: In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above. This form may be photocopied for use out of camp.

Signature of parent or guardian ____ Date ______________________

I also understand and agree to abide with the restrictions placed on my camp activity - Signature of minor ______________________________

(Over)

Camper Name ___________________________________

IMMUNIZATION HISTORY

Required immunizations must be determined locally. Please record date of basic immunizations and most recent booster doses:

Vaccines	Month/Year of Basic Immunization	Month/Year of Last Booster
Diphtheria Pertussis (Whooping Cough) DPT* Tetanus or		
Tetanus Diphtheria TD* or		
Tetanus		
Oral Polio (Sabin) TOPV*		
Injectable Polio (Salk)		
Mumps		
Rubella (German Measles. 3-day measles)		
Measles (hard measles, red measles, Rubeola)		
Other		
Tuberculin test given (most recent)		

Health Examinations by Licensed Physicians: **Date Examined:** ______________________

PHYSICAL MUST BE DONE WITHIN CURRENT YR OF ATTENDING CAMP SESSION 11'

I have examined the above camp applicant. In my opinion, the above camper's condition:

_______does preclude ________ does not preclude his/her participation in an active camp program

Height _______
Weight _______
Blood Pressure _______

The applicant is under the care of a physician for the following condition(s):____

____

Current treatment (include current medications):____

____

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

____

Does the applicant have epilepsy? Yes _______ No _______ Does applicant have diabetes? Yes ______ No ________

Recommendations and Restrictions While at Camp:

Any treatment to be discontinued while at camp? ____

Any treatment to be continued at camp: ____

____

Any medication to be administrated at camp *(specific dosages)*:____

____

Any medically prescribed meal plan or dietary restrictions: ____

____

Any allergies (food, drugs, plants, & insects, etc.): ____

Additional Health Information:

Please Print Physician's Name ____

Licensed Physician's Signature ____ Phone ______________

Address ____

and street city state zip

Date of Form Completion__________________________ *By____

initial if completed by nurse or physician's assistant

s drive camp stuff mailings