

CAMP HEALTH HISTORY and PARENT QUESTIONNAIRE

as developed by
 American Camping Association, Inc. in consultation with
 The American Medical Association and
 The American Academy of Pediatrics

INSTRUCTIONS
 This Health Form may be separated from the Camp Application form and **returned to:** USY/Kadima Encampment
 121 Congressional Lane, Suite #210, Rockville, MD 20852
DEADLINE FOR HEALTH FORM – JULY 23, 2010

THIS SIDE TO BE FILLED OUT BY PARENT/GUARDIAN.

Name _____ Birth Date _____ Sex ____ Age ____ Grade ____
Last First Initial

Parent or Guardian _____ Phone (____) _____

Home Address and City _____

Business and/or Day Phone Number _____ Cell phone _____

If not available in an emergency, notify:
 Name _____ Relationship _____ Phone (____) _____
 Full Address _____

FAMILY MEDICAL/HOSPITAL INSURANCE CARRIER _____

Group # _____ Policy # _____

HEALTH HISTORY: (Check – giving approximate dates and more specific information/details below.)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> ADD with Hyperactivity | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> ADD without Hyperactivity | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Poison Ivy, etc. |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Panic/Anxiety Attacks | <input type="checkbox"/> Insect Stings |
| <input type="checkbox"/> Bleeding Clotting/Disorder | <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> German Measles | <input type="checkbox"/> Psychological Treatment | <input type="checkbox"/> Other Drugs (specify below) |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Substances or Food (specify below) |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Home sickness | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Menstruates (girls) |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Sleep Walking | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stomach Upsets | |

More details, specific allergies or other diseases (from above) _____

Operations, hospitalizations, serious injuries or illnesses (specify and give date) _____

Disability or chronic or recurring illness (specify) _____

Any specific activities to be restricted by physician's or parent's advice _____

Dietary modifications _____

Current medications or treatments _____

Does your child have a history of/or suffer from depression, anxiety disorder, or anger management problems? Please specify _____

Is your child on any medication for behavior modification? _____ Please specify _____

Has your child spent a week away from home previously? _____ Has child ever been denied enrollment or sent home early from a camp or weekend? _____ If yes, please explain _____

Describe any circumstance that would result in (a) situation(s) not compatible with group living or any other possibility of problematic behavior _____

Are there any special family situations that we should be aware of? _____

Has your child suffered any unusual psychological/physical trauma? _____

Please list any past illnesses that we should be aware of (both physical and psychological) _____

AUTHORIZATION AND VERIFICATION (This box must be completed)

The above information and health history is correct and completed to the best of my knowledge.

I, the parent or legal guardian, of the applicant, state that he/she is in good normal health, has no abnormal physical or mental handicaps and has my permission to engage in all prescribed camp activities except as noted under restrictions or modifications above or on the reverse side.

My child has no behavioral or emotional problems that would be detrimental or disruptive to others in attendance at camp.

I hereby give my permission to the camp:

1. To provide ongoing health care.
2. To select medical personnel and to order X-rays, routine tests or treatments for my child.
3. In case of medical emergency, accident or a serious health problem where immediate treatment is deemed necessary, I give permission to the physician selected by the Regional Youth Director, Regional Kadima Director or the person designated by the Region to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named above. In such case, every effort will be made to contact the parent or guardian of the applicant.

I am aware that this form may be photocopied for use by medical caregivers.

Signature of parent or legal guardian _____ Print Name _____ Date _____

PHYSICAL EXAMINATION

To be filled out by licensed physician within twelve months prior to camp (MUST be dated after August 23, 2009).
Other medical forms may be accepted (from other camps, summer programs, etc.) as long as the same information is included as requested below.

NAME OF CHILD: _____ DATE OF EXAMINATION: _____

Please record the date (month and year) of basic immunization and most recent booster doses:

| Vaccines | Year of Basic Immunization | Year of Last Booster |
|--|----------------------------|----------------------|
| Diphtheria | 1 | 1 |
| Pertussis (Whooping Cough) | 2 | 2 |
| Tetanus | 3 | |
| or | | |
| Tetanus | | |
| Diphtheria | | |
| or | | |
| Tetanus | | |
| Oral Polio (Sabin)* TOPV | | |
| Injectable Polio (Salk) | | |
| Measles (hard measles, red measles, Rubeola) | | |
| Mumps | | |
| Rubella (German measles, 3-day measles) | | |
| Other | | |
| Tuberculin test given _____ (most recent) | | |

Health Examination by Licensed Physician

Code: √ -- Satisfactory

x – Not Satisfactory (explain)

Hgt. _____ B.P. _____ Urinalysis test done _____ Wt. _____ Hgb. Test done _____
 Eyes _____ Extremities _____ Glasses _____ Posture (Spine) _____ Ears _____
 Skin _____ Nose _____ Allergies (please specify) _____
 Teeth _____ Heart _____ Menstrual history _____ Lungs _____ Abdomen _____
 Throat _____ Genitalia _____ Hernia _____ General appraisal _____

I have examined the above camp applicant on (date) _____
 In my opinion, the above's condition does _____/does not _____ preclude his/her participation in an active camp program.

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

Current treatment (include current medication): _____

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

Does applicant have epilepsy? Yes _____ No _____ Does applicant have diabetes? Yes _____ No _____

Recommendations and Restrictions While at Camp (diet, medicine, treatment, etc.) _____

Additional Health Information _____

X Licensed Physician's Signature _____ *By _____

Please print physician's full name: _____

Full Address _____ Phone _____

*Initial if completed by nurse or physician's assistant.