Camp Jotoni Health History and Examination Form

Camp Jotoni requires the **Health exam (back page) must be completed by approved licensed medical personnel** annually.

Name: _____ Date: _____ Date of Birth: _____

Home Address: _____
Street Address City State Zip

Gender: ☐ Male ☐ Female

Emergency Contact Information:

Custodial Parent / Guardian _____ Phone: _____

Home Address: _____
Street Address City State Zip

Other Contact Info: Work Phone: _____ Cell Phone: _____

Second Parent or Guardian: _____ Phone_____

Home Address: _____
Street Address City State Zip

Other Contact Info: Work Phone: _____ Cell Phone: _____

Third Emergency Contact: (used if the above are not available)

Name: _____ Relationship: _____

Phone: _____ Work: _____ Cell: _____

Insurance Information:

Is the applicant covered by family medical /hospital insurance: ☐ Yes ☐ No
If Yes, indicate carrier or plan name_____ Group # _____

Please photocopy front and back of insurance card and bring to camp with you.

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. 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. It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal 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.
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

Signature: _____ Date: _____
(parent / guardian, or adult staff member)

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature: _____ Date: _____
(parent /guardian,or adult staff member)

Health History Name:_____

The following information must be filled in by the parent/guardian, 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 –include insect stings, hay fever, asthma, animal dander, etc…

_____ _____

_____ _____

_____ _____

Signature of parent / guardian: _____ **Date:** _____

Over The Counter Medications

Please complete the **Over The Counter Medications** Chart below. Prescription medications should be listed on page 4 of the Health History and Examination form. The Over The Counter Chart can be completed by a parent, guardian, or professional care provider as long as it is reviewed and signed by a Licensed Medical Professional on page 4 of this document. If prescription medication is required for any of the symptoms below it must be listed on the Prescription Medications section on page 4 and 5 of this document.

OTC Medication	Symptoms	Dosage	Frequency
	Headache / Pain		
	Diarrhea		
	Cough		
	Sore Throat		
	Congestion		
	Hay Fever		
	Menstruation Cramps		
	Other		

Explain any restrictions to activity: (what cannot be done, what adaptations or limitations are necessary)

_____

_____

Health History

Name: _____

General Questions (Explain "yes" answers below.)

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐
16. Ever had back problems?	☐	☐
17. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
18. Have an orthodontic appliance being brought to camp?	☐	☐
19. Have any skin problems (e.g. itching,rash, acne)	☐	☐
20. Have diabetes?	☐	☐
21.Have asthma?	☐	☐
22.Had mononucleosis in the past 12 months?	☐	☐
23.Had problems with diarrhea/constipation?	☐	☐
24. Have problems with sleepwalking?	☐	☐
25.If female, have an abnormal menstrual history?	☐	☐
26. Have a history of bed-wetting?	☐	☐
27.Ever had an eating disorder?	☐	☐
28.Ever had emotional difficulties for which professional help was sought?	☐	☐

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

_____

_____

_____

Name of Physician: _____ Phone: _____

Name of Dentist: _____ Phone: _____

Which of the following has the participant had?		Immunizations							
	Measles	Vaccine	Dates	Mo / Yr	Mo / Yr	Mo / Yr	Mo / Yr	Mo / Yr	Mo / Yr
	Chicken Pox	DTP							
	German Measles	TD (tetanus/diphtheria)							
	Mumps	Tetanus							
	Hep. A	Polio							
	Hep. B	MMR							
	Hep. C	Or Measles							
TB Mantoux Test		Or Mumps							
Date of Last Test:		Or Rubella							
(must be within 3 years at time of attendance)		Haemophilus Influenza B							
		Hepatitis B							
Positive ☐ 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 camp should be aware.

_____

_____

Health History and Examination Form

_____ was examined _____(date)
(camper / staff name)

BP _____ Height _____ Weight _____

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:

Medications are defined as any substance, prescription, or otherwise, that is administered on a regular basis to improve or maintain their health. Camp must have a copy of each prescription at time of stay. Med. Label must match this document.

☐ This person takes medications as follows ☐ This person takes no medication on a routine basis.

Med # 1 _____ Dosage_____ Specific Times_____

Reason For Taking: _____

Med # 2 _____ Dosage_____ Specific Times_____

Reason For Taking: _____

Med # 3 _____ Dosage_____ Specific Times_____

Reason For Taking: _____

(Please use Addendum page if more space is needed.)

Medically prescribed meal plan or dietary restrictions: _____

_____

Known Allergies: _____

_____

Description of Limitations or restrictions on activities: _____

_____

The content of this Health History document has been reviewed by a Licensed Medical Professional and represents an accurate description of the health / medical needs of this person.
****Signature of Licensed Medical Professional:**

Printed: Title:

Address:

Phone: