Health History & Examination Form for Southwoods Summer Camp

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 must be filled out by the parents/guardians of minors or by adults themselves. Updates are required annually. The Health exam must be completed by approved licensed medical personnel every year.

LIT Program

JULY 5, 2013 – AUGUST 7, 2013

Last Name:_____ **First:** _____ **Middle:** _____

Address: _____ **Social Security Number:**_____

City/Town:_____ **Home State:**_____ **Date of Birth:** _____

Zip Code:_____ **Home Phone:**_____ **Gender**(circle)**: Female Male**

Custodial parent/guardian: _____ **Cell Phone:** _____

Second parent/guardian:_____ **Cell Phone:**_____

If not available in an emergency, please notify: _____ **Relation to child:**_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

IMPORTANT – THIS BOX MUST BE COMPLETE FOR ATTENDENCE

The health history is correct and complete as far as I know. The person herein named has permission to engage in all 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 the 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 purpose of disdosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability Act of 1996. I hereby agree (pursuant to 45 CFR, 164.510(b)) to the disdosure 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 persons 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 of Parent or Guardian or adult camper/staff: _____

Printed Name: _____ Date:_____

Southwoods Camper Insurance Information

Last Name:_____**First:**_____ **Middle:** _____

Address:_____ **Social Security Number:**_____

City/Town:_____ **State:**_____ **Date of Birth:**_____

Zip Code:_____ **Home Phone:**_____ **Gender**(circle): **Female Male**

LIT Program

JULY 5, 2013 – AUGUST 7, 2013

Please Choose One of the Insurance Options Below

Option 1: Private Insurance (This option is only available to domestic families. All co-pay bills will be sent to the address above. A photo copy of the front and back of the health insurance card must be attached to this form.)

Name of Parent/Guardian through whom the group or family plan is written:

_____

Name of Insurance Company that underwrites your group or family plan:

_____

Name of Company (where employed) which enrolls your family, if in a group plan:

_____

Group Number: _____ ID Number:_____ **RX Bin#(Required):** _____

Plan:_____ Type:_____ Effective Date:_____

Option 2: Southwoods Insurance (All international families must choose this plan. You may also choose this plan if you do not carry a Hospital/Medical Insurance Policy for your family or if you wish to complement your family policy. Please attach a check for $150 to this form.)

The insured camper will receive the following:
Coverage for each accident, up to a maximum $5,000
Coverage for each illness, up to a maximum $5,000
Coverage for accidental death, $7,500

Coverage is in effect for up to 26 weeks following each accident/illness for necessary hospital, medical, surgical care, services and supplies such as prescription medications, x-rays and nursing.

____ **Yes.** Please enroll the camper listed in the Southwoods Camper Accident/Illness Plan for the charge of $150

Parent Signature:_____ **Date:**_____

Health History

The following information must be filled in by the parent/guardian, or adult camper/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

_____ _____

_____ _____

_____ _____

_____ _____

Food allergies

_____ _____

_____ _____

_____ _____

Other allergies (include insect stings, hay fever, asthma, animal dander, etc.)

_____ _____

_____ _____

_____ _____

RESTRICTIONS

The following restrictions apply to this individual. (Please check all that apply)

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)

_____

_____

_____

Medications Being Taken

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Medications other than injectables, inhalers and liquids must come to camp via CampPacks. All injectables, inhalers and liquids must arrive at camp prior to camper arrival date for the infirmary staff to process. Please do not send over the counter medication to camp. If your child takes an over the counter medication on a routine basis then that medication must go through CampPacks. All other over the counter medication will be provided by Southwoods.

___ This person takes NO medications on a routine basis

___ This person takes the medications as follows:

Med #1 _____ Dosage _____ Daily Time Taken _____

Reason for taking _____

Med #2 _____ Dosage _____ Daily Time Taken _____

Reason for taking _____

Med #3 _____ Dosage _____ Daily Time Taken _____

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:_____

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.

_____

_____

_____

_____

_____

_____

Name of family physician: _____ **Phone:** _____

Address: _____

Name of family dentist/orthodontist: _____ **Phone:** _____

Address: _____

General Questions (Explain "yes" answers below)

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infections 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? …	___	___
18. Have an orthodontic appliance being brought to camp? ……...	___	___
19. Have any skin problems? …….	___	___
20. Have diabetes? …….	___	___
21. Have asthma? ……..	___	___
22. Had mononucleosis within the last 12 months? …….....	___	___
23. Had problems with diarrhea or 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 health was sought?	___	___

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

_____

_____

_____

Which of the following has the participant had? ___ Measles ___ Chicken Pox ___ German Measles ___Mumps

___ Hepatitis A ___ Hepatitis B ___ Hepatitis C

Please give all dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
MMR	_____	_____				
Or Measles	_____	_____				
Or Mumps	_____	_____				
Or Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Chicken Pox	_____	_____				

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (Date must be within one year of your camper's session start date)

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 camp _____

_____

Signature of Licensed Medical Personnel _____

Printed _____ **Title** _____

Address _____

Phone _____ **Date** _____

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven (7) or more nights.

Camper's Name: _____ Date of Birth: _____

Session: LIT

Check one box and sign below.

☐ My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years.
Date received: _____

[Note: The vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.]

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.

Printed Name of Parent or Guardian: _____

Signature: _____ Date:_____
(Parent/Guardian)