2016 CAMP LONGHORN MEDICAL FORM

Please return all pages of this form by: May 1, 2016

Parents are responsible for omission of information

BRANCH: Inks Lake Indian Springs C3
TERM: 1st 2nd 3rd 4th

Camper's Name_____ **Age**_____ **Sex**_____
Last First MI

Home Address_____ **Birth date**_____
Street & Number City State Zip

Parent or Guardian_____ Phone_____
Best number to call in an emergency

Work Phone_____ Cell Phone_____

Second Parent or Guardian or Emergency Contact _____Home Phone_____

Address (*If different from above)* _____ Cell/Work Phone_____

Other Emergency contacts:
Name _____Home Phone _____

Address_____ Cell/Work Phone_____

CAMP LONGHORN MEDICAL QUESTIONNAIRE AND HEALTH HISTORY

In order for your child to participate in camp activities:

PARENTS: Please read this questionnaire before filling out or signing. Answer the following questions on your camper's past or present medical history by circling a **YES** or **NO**. If any of these items apply with a **YES** response, your physician must fully complete the **bottom half** of the second page of this form. **After completing this page, please complete top half of page two. Parents are responsible for omission of information.**

DOES YOUR CAMPER CURRENTLY HAVE OR EVER HAD THE FOLLOWING:

YES	***NO***	Asthma? (If activity induced please indicate here_____)
YES	***NO***	Back or spinal surgery, recurring back problems?
YES	***NO***	Back, arm, leg problems following surgery, injury or fracture?
YES	***NO***	Behavioral health, mental or psychological problems?
YES	***NO***	Blackouts or fainting (full/partial loss of consciousness)?
YES	***NO***	Know blood disease or disorders?
YES	***NO***	Diabetes?
YES	***NO***	Dysentery or dehydration requiring hospitalization or medical intervention?
YES	***NO***	Ear disease or surgery, hearing loss or problems with balance?
YES	***NO***	Ear infections (frequent)?
YES	***NO***	Epilepsy, Seizure, Convulsions or take medication to prevent them?

YES	***NO***	Frequent colds, sinusitis or bronchitis?
YES	***NO***	Frequent or severe suffering from motion sickness (seasick, carsick, etc.)?
YES	***NO***	Frequent or very severe hay fever or allergy attacks?
YES	***NO***	Head injury with loss of consciousness in past 5 years?
YES	***NO***	Heart defect/disease?
YES	***NO***	Heart surgery, angina, or blood vessel surgery?
YES	***NO***	High blood pressure or take medicine to control?
YES	***NO***	Inability to perform moderate exercise?
YES	***NO***	Kidney disease/injury
YES	***NO***	Lung disease or injury?
YES	***NO***	Recurring complicated migraine headaches or take medicine to prevent them?
YES	***NO***	Ulcers?

Acknowledgement of Review of Notice of Privacy Practices
I have reviewed this office's notice of Privacy Practices (HIPAA) online (***www.camplonghorn.com***) which explains how my medical information will be used and disclosed. I authorize any physician, nurse or health care provider, to communicate with the medical staff and director of Camp Longhorn, or his/her designee about my child's medical condition, treatment and/or prognosis.

Permission to Treat
The information I have provided about my child's medical history is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health conditions. The person listed above has permission to engage in all camp activities.
I hereby give Camp Longhorn permission to:

1. Provide ongoing health care, including but not limited to basic or emergency first aid, administration of medication brought from home, prescribed by camp physician, or over the counter medication that may be provided by camp.
2. Select medical personnel to order X-rays, routine test or other out of camp treatment for the person listed above.

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, to order injection and/or anesthesia and/or surgery for the person named above. This form may be photocopied for use out of camp.

Signatures of parents or guardians: _____ **Date:**_____

Signatures of parents or guardians: _____ **Date:** _____

PARENTS ARE RESPONSIBLE FOR OMISSION OF INFORMATION

IMMUNIZATION HISTORY

Record month & year of most recent booster doses

State form required for Exemption to Immunizations

VACCINES	YEAR OF LAST BOOSTER
Diphtheria Pertussis (Whooping Cough) } **DPT** Tetanus or	1 2
Tetanus Diphtheria } **TD** or	
Tetanus	
Oral Polio (Sabin)* **TOPV**	
Injectable Polio (Salk)	
Measles	
Mumps	
Rubella (German measles, 3-day measles)	
Varicella (Chicken Pox)	
Hepatitis B Series	
Tuberculin test given _____	
Meningococcal vaccine	

PLEASE COMPLETE with "yes", "no" and/or dates

Childhood Diseases:

Chicken Pox_____

Measles _____

German Measles_____

Mumps_____

(Please circle YES or NO-- list allergies if YES)

FOOD ALLERGIES		DRUG ALLERGIES	
NO	**YES**	**NO**	**YES**

Will your child bring medication to camp?

NO YES

IF YOUR CHILD IS TAKING MEDICATION WHILE AT CAMP, PLEASE FILL OUT THE MEDICATION ADMINISTRATION FORM AND SEND TO CAMP WITH THE MEDICATION.

HEALTH EXAMINATION BY LICENSED PHYSICIAN: PLEASE NOTE: *AN EXAM IS NEEDED ONLY IF YOU ANSWERED "YES" TO ANY OF THE HEALTH HISTORY QUESTIONS*

Date Examined: _____ Height_____ Weight_____

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

_____

Does the above condition prevent his/her participation in any camp activities? Yes _____ No _____

If yes, list activities in which camper may not participate: _____

_____

Current treatment (*include current medications)*: _____

_____

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:

Any treatment to be continued at camp:_____

_____

Any medication to be administered at camp (*specific doses*):_____

_____

Any Allergies (food, drugs, plants & insects, etc.):_____

_____

Type of reaction:_____

Additional Health Information:_____

_____

Licensed Physician's Signature:

_____Phone:_____

Area/Number

Address:_____

Street & Number City State Zip

Date of Form Completion:_____*By:_____

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