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Vishwa Hindu Parishad of America Inc.: Vivekananda Family Camp

Medical-1

Health History and Medical Form

Please fill out both pages of this form carefully and in detail.
Your doctor's office must sign at the bottom of page 2. Please attach sheet for additional information.

Please complete a separate form for each participant: Volunteer, Camper or Accompanying Child.

Name of Participant: _____
First *Middle* *Last*

Date of Birth *(mo/day/yr):* _____ Male: ☐ Female: ☐

Emergency Contact Name & Phone # : _____

Relationship to Camper/Volunteer: _____

Family Physician: _____ Dr. Phone: _____

Family Medical Insurance Company: _____

Policy # : _____ Name of Insured Policyowner: _____

→ **A copy of BOTH sides of the insurance card must accompany this application**

→ **A copy of Immunization Records are also MANDATORY for anyone under 18**. These records can be obtained from child's physician's office, and typically includes MMR, Polio, DPT and Hep-B vaccination dates.

→**For adults over 18, please provide date of last tetanus shot?** _____

Health History. Check those that apply; Have you had or do you have any of the following? Please provide an explanation for any Yes answers:

Chicken Pox	☐ Yes	☐ No	Learning Difficulties	☐ Yes	☐ No
Measles	☐ Yes	☐ No	Physical/Social/Emotional Needs	☐ Yes	☐ No
German Measles	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Mumps	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Mononucleosis	☐ Yes	☐ No	Bleeding Disorders	☐ Yes	☐ No
Seizure	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Musculoskeletal Disorder	☐ Yes	☐ No	Operations/Serious Injuries.	☐ *Yes*	☐ *No*
Ear Infection	☐ Yes	☐ No	Chronic/Recurring Illness	☐ Yes	☐ No
Heart Disease/Defect	☐ Yes	☐ No	Dietary Restrictions	☐ *Yes*	☐ *No*
Allergies (list)					
Food	☐ Yes	☐ No	Animal	☐ Yes	☐ No
Drug	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No
Insect Sting	☐ Yes	☐ No	Plant/Pollen	☐ Yes	☐ No

Other* : _____

(* *Please attach sheet for additional information*)

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Vishwa Hindu Parishad of America Inc.: Vivekananda Family Camp

Medical-2

Health History and Medical Form

Please fill out both pages of this form carefully and in detail.
Your doctor's office must sign at the bottom of page 2. Please attach sheet for additional information.
Please complete **a separate** form for each participant: Volunteer, Camper or Accompanying Child.

Name of Participant:_____
First *Middle* *Last*

Special Conditions to be watched for (i.e. wetting, fainting, menstrual cramps, etc.) * :_____

_____

Hospital/Emergency Room visits during the last 6 months?: ☐Yes: ☐No: If yes then for what reason* ?_____

_____

_____

This health history is correct as far as I know and the person described has permission to engage in all camp activities except as noted above. I will notify Camp authority if there is any change in health conditions of the participant.

I give permission:

1) To the medical personnel selected by the Camp authority to hospitalize, secure proper treatment such as anesthesia or surgery, and to provide or arrange necessary transportation for the participant.

2) For Camp Health Supervisor to treat minor injuries or illness as directed by orders of a licensed physician; administer prescription medication brought to camp in it's original container, labeled with the participant's name, physician' name and dosage; and/or administer over- the- counter medication unless otherwise specified below.

Medications: List of over-the-counter medication that ***may not*** b*e* administered to the participant:_____

_____

_____

☐ The participant does **NOT** take any medication on a routine basis.

☐ The participant takes the following medicines (Please include ALL medications and attach sheet* for more):

Med # 1_____Dosage_____When (how often) taken?_____

Reason for taking:_____

Med # 2_____Dosage_____When (how often) taken?_____

Reason for taking:_____

Med # 3_____Dosage_____When (how often) taken?_____

Reason for taking:_____

Signature (Parent or Guardian for participant under 18):_____Date:_____

To be completed by Licensed Physician or State Approved Nurse Practitioner:

Name of Participant:_____

Date of Examination (must be within last two years):_____

In my opinion, this person's condition allows participation in active camp program subject to the following limitations, restrictions, treatment to be continued at the camp:

Signature of Licensed Health Care Provider:_____Date:_____

Print name and address of the above:_____Phone:_____

(* *Please attach sheet for additional information*)