



# Camp Tapawingo Health Form

Session: \_\_\_\_\_

### CAMPER INFORMATION (Please print clearly)

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age at camp \_\_\_\_

Address \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_ Phone(\_\_\_\_)

Social Security Number of Camper \_\_\_\_\_ Gender:  Male  Female

Mother's Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ Email Address \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ Email Address \_\_\_\_\_

### EMERGENCY CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Physician/Pediatrician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Orthodontist \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Dentist \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

### INSURANCE INFORMATION

Is the camper covered by family medical/hospital insurance?  Yes  No

If so, indicate Insurance Company: \_\_\_\_\_

Group # \_\_\_\_\_ Prescription Plan # \_\_\_\_\_

Name of insured \_\_\_\_\_ Relationship to participant \_\_\_\_\_

**PLEASE INCLUDE A PHOTOCOPY OF HEALTH INSURANCE CARD TO BE USED IN THE EVENT THAT MEDICAL TREATMENT OR PRESCRIPTION IS REQUIRED.**

### Parent Authorization and Permission to Provide Necessary Treatment or Emergency Care

(MUST be completed before child can be admitted to camp)

This health history is correct and complete as far as I know and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by Camp Tapawingo to order X-rays, routine tests, and/or seek emergency medical treatment. I agree to the release of any records necessary for insurance purposes and give my permission to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director and/or his/her Assistant(s) to secure and administer treatment, including hospitalization, for the person named above. The completed form may be photocopied for trips out of camp.

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of Camper \_\_\_\_\_ Date \_\_\_\_\_

**HEALTH HISTORY**

**ALLERGIES (List all known)**

		Describe reaction and management of the reaction
<b>Medication</b>	1.	1.
	2.	2.
<b>Food</b>	1.	1.
	2.	2.
<b>Other</b>		

**General Questions** (Explain "yes" answers below)

Has/does the participant:

- |  | Yes                      | No                       |   | Yes                      | No                       |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Had any recent injury, illness or infectious disease?     | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ever been diagnosed with a heart murmur?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition?            | <input type="checkbox"/> | <input type="checkbox"/> | 17. Ever had back problems?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized?                                   | <input type="checkbox"/> | <input type="checkbox"/> | 18. Ever had problems with joints (ex. knees, ankles)?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery?   | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have an orthodontic appliance being brought to camp?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches?                                  | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have any skin problems (ex. itching, rash, acne)?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury?                                   | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have diabetes?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious?                            | <input type="checkbox"/> | <input type="checkbox"/> | 22. Have asthma?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eyewear?             | <input type="checkbox"/> | <input type="checkbox"/> | 23. Had mononucleosis in the past 12 months?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections?                         | <input type="checkbox"/> | <input type="checkbox"/> | 24. Had problems with diarrhea/constipation?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out during or after exercise?                | <input type="checkbox"/> | <input type="checkbox"/> | 25. Have problems sleep-walking?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise?                | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have an abnormal menstrual history?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had seizures?                                       | <input type="checkbox"/> | <input type="checkbox"/> | 27. Have a history of bedwetting?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had chest pain during or after exercise?            | <input type="checkbox"/> | <input type="checkbox"/> | 28. Ever had an eating disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Ever had high blood pressure?                            | <input type="checkbox"/> | <input type="checkbox"/> | 29. Ever had emotional difficulties for which professional help was sought? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Ever had measles, chicken pox, german measles, or mumps? | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

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

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**Use the space below to provide any additional information about the participant's behavior of which the camp should be aware.**

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# Physical Examination - To be filled out by Physician

Each camper must have had a physical examination by a physician within 12 months of the camper's week(s) at camp.

Camper Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
*Last* *First*

I have examined the above camp participant. Date of examination \_\_\_\_\_

B/P \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Urine \_\_\_\_\_ Vision \_\_\_\_\_

Eyes: \_\_\_\_\_ Posture/Spine: \_\_\_\_\_  
 Ears: \_\_\_\_\_ Skin: \_\_\_\_\_  
 Nose: \_\_\_\_\_ Hernia: \_\_\_\_\_  
 Throat: \_\_\_\_\_ Teeth: \_\_\_\_\_  
 Heart: \_\_\_\_\_ Abdomen: \_\_\_\_\_  
 Lungs: \_\_\_\_\_

### IMMUNIZATION HISTORY:

DPT or DR or TD	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Polio	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Tetanus	Date: _____				
Measles	Date: _____				
Mumps	Date: _____				
Rubella	Date: _____				
Chicken pox/varicella	Date: _____				
Haemophilus influenza B	Date: _____				
Hepatitis B	Date: _____				
Hepatitis A	Date: _____				
TB Mantoux Test	Date of last Test: _____	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative		

### RECOMMENDATIONS WHILE AT CAMP:

Special Diet: \_\_\_\_\_

Medications:

- This person takes NO medications on a routine basis.
- This person takes medications as follows:  
 (Any medication prescriptions must arrive in the original containers with the pharmacy label attached)

Medication	Dosage	Specific times taken each day	Reason for taking
1.			
2.			
3.			

Activity Restrictions: \_\_\_\_\_

Additional Information for Health Care Staff: \_\_\_\_\_

**New York State Law requires this section to be filled out by a physician in order for our Health Director to dispense over-the-counter, non-prescription medication to your child when needed.**

MEDICATION	DOSAGE SCHEDULE	AGREE WITH ORDER	COMMENTS
Acetaminophen Liquid, Chewable, or Tablet	Per label instructions by age/weight	YES / NO	
Ibuprofen Liquid, Chewable, or Tablet	Per label instructions by age/weight	YES / NO	
Cough Suppressants	Per label instructions by age/weight	YES / NO	
Pepto Bismol	Per label instructions by age/weight	YES / NO	
Antacids	Per label instructions by age/weight	YES / NO	
Kaepectate or Immodium AD	Per label instructions by age/weight	YES / NO	
Benadryl Capsules Oral for allergic reactions	Per label instructions by age/weight	YES / NO	
Chlor-trimeton	Per label instructions by age/weight	YES / NO	
Topical Antibiotics Bacitracin, Neosporin	Per label instructions	YES / NO	
Silvadene Cream	Per label instructions	YES / NO	
Topical Antipruities Caladryl Lotion	Per label instructions	YES / NO	
Visine-eyes	Per label instructions	YES / NO	
Anbesol: tooth pain	Per label instructions	YES / NO	
OTC RID or NIX For lice	Per label instructions	YES / NO	
Albuterol Inhalation Sol .83% History of asthma or difficulty breathing	Per camp medical direction	YES / NO	
Oxygen	Per camp medical direction	YES / NO	
Other:			
Other:			

**\*If there are other over-the-counter, non-prescription medications that the camper takes, physician must include each one in the table above, or we will not be able to give them to your child.**

*I have examined the patient herein described and have reviewed the health history. It is my opinion that this child is physically able to engage in the regular camp activities, except as noted.*

**Physician's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please Print Name** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**Address** \_\_\_\_\_