Health History & Examination Form 2020

Jameson Camp
2001 Bridgeport Road • Indianapolis, IN 46231-0156 • (317) 241-2661 • fax (317) 241-2762

Parent/Guardian must complete pages 1–3.

Page 4 must be completed by a licensed Physician or Nurse Practitioner prior to arrival at camp.
PAGE 4 **CAN** BE TURNED IN SEPARATELY FROM THE REST OF THIS FORM.

★ *We **cannot** allow your child to remain at camp without this form **and** immunization information* ★

Please print all information clearly in **blue or black ink**.

Camper Name _____ Birth date ____/____/____ Age _____
Last First M.I.

Home Address _____ _____ _____ _____
Street City State Zip Code

PRIMARY EMERGENCY CONTACT INFORMATION (with legal custody to be contacted in case of illness or injury)

Custodial Parent/Guardian _____ Relationship _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell: ( ) _____

EMERGENCY CONTACT INFORMATION (OTHER THAN PRIMARY PARENT OR GUARDIAN)

Name _____ Relationship _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell: ( ) _____

Name _____ Relationship _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell: ( ) _____

DOCTOR INFORMATION

• **Family Doctor Name** _____ **Phone Number** _____

INSURANCE INFORMATION

****YOU *MUST* PROVIDE INSURANCE INFORMATION****

• **Is the participant covered by medical healthcare insurance?** YES NO

• **If yes: Insurance Co. Name** _____ **Policy No.** _____

Name of Policy Holder _____ **Relationship** _____

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE

The information and statements contained within this form are true and correct to the best of my knowledge.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays and routine tests. I agree to the release of any records necessary for insurance purposes.

I give permission to Jameson Camp, Inc. to provide or arrange necessary related transportation.

In the event of an emergency and/or my inability to communicate, I hereby give permission to the physician and/or medical facility selected by the Program Director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Parent/guardian signature _____ **Date** _____

Printed Name _____

Camper Name _____ Birth date ____/____/____
Last First M.I.

HEALTH HISTORY

ALLERGIES (List all known)

☐ Child has **NO known allergies**

This child is allergic to: ☐ Food ☐ Medicine ☐ Environment *(insect stings, hay fever, etc.)* ☐ Other

Describe <u>what the camper is allergic</u> to, if it's <u>airborne or consumptive</u>, the <u>reaction seen</u>, and <u>management</u> of the reaction:

_____

Does your child require an EpiPen? *(please circle)* Yes No

If yes, please provide a non-expired EpiPen to our Health center Staff upon check-in on your child's first day of camp.

DIETARY RESTRICTIONS (e.g. vegetarian)

☐ Child has **NO dietary restrictions**

These dietary restrictions apply to this child: ☐ Vegetarian ☐ Does not eat pork ☐ Other
☐ Does not eat dairy products *(describe below)* ☐ Food allergies not listed above *(describe if consumptive or airborne)*

Details of dietary restrictions and reactions: _____

_____

MEDICATIONS

Please list ALL medications (including over-the-counter/nonprescription and prescription drugs) taken routinely.

☐ Child takes **NO medication** on a routine basis.

☐ Child **takes medication** as follows: *Attach additional pages if necessary*

Name of Medication	Date Started	Reason for taking	When it is given	Amount/Dose	How it is given
			☐ Breakfast ☐ Bedtime ☐ Lunch ☐ Other time: ☐ Dinner		
			☐ Breakfast ☐ Bedtime ☐ Lunch ☐ Other time: ☐ Dinner		
			☐ Breakfast ☐ Bedtime ☐ Lunch ☐ Other time: ☐ Dinner		
			☐ Breakfast ☐ Bedtime ☐ Lunch ☐ Other time: ☐ Dinner		

Medications <u>must</u> be in the original and <u>current</u> packaging/bottle that identifies the prescribing physician (if a prescription drug), the name and expiration date of the medication, the dosage and the frequency of administration.

Please note any medication(s) taken during the year that the child does not take during the summer:

_____

_____

NON-PRESCRIPTION MEDICATIONS:

The following non-prescription medications may be stocked in the camp Health Center and are used on an <u>as needed basis</u> to manage illness and injury. **Your signature below gives permission for Jameson Camp staff to administer medication when needed to your child.** Medication will be administered only by label instructions.

Cross out those the camper should <u>not</u> be given *(example: permission: "Maalox" , no permission: "~~Maalox~~").*

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Children's ibuprofen liquid
Children's Tylenol (chewable or liquid)
Antihistamines (diphenhydramine/Benadryl, loratadine/Claritin, cetirizine/Zyrtec)
Decongestant (phenylephrine/Sudafed PE, pseudoephedrine/Sudafed)
Cough syrup (guaifenesin/Robitussin, dextromethorphan/Robitussin DM, Dimetapp)
Sore throat spray; generic cough drops
Antacids (Tums, Pepto-Bismol, Kaopectate)
Maalox
Milk of Magnesia
Antibiotic ointment
1% Hydrocortisone cream
Calamine lotion
Wound cleanser
Topical analgesics (BenGay, Icy Hot)
Sunscreen
Aloe
Eye wash
Insect repellant

By signing below, I give the staff of Jameson Camp, Inc. permission to administer medication **<u>not</u>** crossed out on the list above.

Parent/guardian signature _____ Date _____

Camper Name _____ Birth date ____/____/____
Last First M.I.

GENERAL QUESTIONS (Explain "yes" answers)

Does or Has your child….

		Y	N			Y	N
1.	Had any recent injury, illness or infection?	☐	☐	17.	Have a hearing impairment?	☐	☐
2.	Have a chronic or recurring illness/condition?	☐	☐	18.	If female, have an abnormal menstrual history?	☐	☐
3.	Ever been hospitalized?	☐	☐	19.	Have a history of bedwetting?	☐	☐
4.	Ever had surgery?	☐	☐	20.	Ever had an eating disorder?	☐	☐
5.	Have frequent headaches?	☐	☐	21.	Have cerebral palsy?	☐	☐
6.	Ever had a head injury, concussion or been knocked unconscious?	☐	☐	22.	Ever had emotional difficulties for which professional help was sought?	☐	☐
7.	Wear glasses, contacts or protective eye wear?	☐	☐	23.	Have sleeping disorders (e.g. apnea, sleepwalking)?	☐	☐
8.	Have frequent ear infections or tubes in their ears?	☐	☐	24.	Have any skin problems (e.g. itching, rash, acne)?	☐	☐
9.	Ever passed out or been dizzy during or after exercise?	☐	☐	25.	Ever had problems with back or joints (e.g. knees, ankles)?	☐	☐
10.	Ever had seizures, convulsions or epilepsy?	☐	☐	26.	Have a kidney ailment?	☐	☐
11.	Ever had chest pain during or after exercise?	☐	☐	27.	Use an inhaler or ventilator?	☐	☐
12.	Ever had high blood pressure?	☐	☐	28.	Have diabetes?	☐	☐
13.	Ever been diagnosed with a heart murmur?	☐	☐	29.	Have asthma or breathing difficulty?	☐	☐
14.	Have frequent sore throats?	☐	☐	30.	Had mononucleosis in the past 12 months?	☐	☐
15.	Have a weight problem (over or under)?	☐	☐	31.	Have problems with diarrhea/constipation?	☐	☐
16.	Ever tested + for an infectious Disease? (e.g. tuberculosis, hepatitis, etc…)	☐	☐	32.	Use assistive devices? (e.g. wheelchair, monitors, prosthetics, etc.)	☐	☐

Please explain any "Yes" answers, noting the number of the question(s):

_____

_____

_____

The following immunizations are required:

Children in grades K-5: 3 Hepatitis B, 5 Diphtheria, Tetanus & Pertussis (DTaP), 4 Polio, 2 Measles/Mumps/Rubella, 2 Varicella, 2 Hep A
Children in grades 6-12: 3 Hepatitis B, 5 DTaP, 4 Polio, 2 Measles/Mumps/Rubella, 2 Varicella, 2 Hep A, 1 Tetanus and Pertussis, 1 Meningitis (*OR the date of disease(s), indicated to the right)*

Please provide a copy of this camper's immunization records to date OR sign below to confirm they are up to date with all immunizations and provide the date of their most recent tetanus shot

Mo/Yr

Date of most recent tetanus shot *(Required)*: _____

Parent/guardian signature _____ Date _____

ILLNESSES

Indicate which diseases the child has had:

		Mo/Yr
☐ **Chicken Pox:**	**Date:**	_____
☐ **Hepatitis A**		
☐ **Hepatitis B**		
☐ **Hepatitis C**		
☐ **Other _____**		

TB Mantoux Test
Date of last test _____
Result: ☐ Positive ☐ Negative

If your camper has **not been fully immunized,** you must provide a **medical document** or **religious statement** to explain why your camper is exempt from specific immunizations. Also sign in agreement with the following statement:

By signing below, I understand and accept the risks to my child from not being fully immunized.

Parent/guardian signature _____ Date _____

ACTIVITY RESTRICTIONS (i.e., limitations, what cannot be done, what adaptations are necessary)

_____

_____

ADDITIONAL INFORMATION (e.g tantrums, strong dislikes, sleep walks, nightmares, family changes)

• Any other information about the participant's **behavior, physical, emotional or mental health** which camp should be aware of?

_____

_____

HEALTH CARE RECOMMENDATIONS and

PHYSICAL EXAM BY LICENSED PHYSICIAN

Or Nurse Practitioner

Camper Name _____ Birth date _____/_____/_____
Last First M.I.

This portion is to be completed prior to arrival at camp. All information must be completed by authorized personnel.

S = ***Satisfactory*** **N =** ***Not Satisfactory*** **W =** ***Needs Watching***

General Appraisal_____
Feet _____
Skin: Scabies _____
Athlete's Foot _____
Impetigo_____
Eyes: Vision_____
Discharge _____
Glasses/Contacts _____
Nose: Discharge _____
Ears: Hearing_____ Discharge_____

Weight _____lbs ***Height*** _____ inches
BP _____/_____
Throat _____
Teeth _____
Lungs_____
Abdomen_____
Hernia _____
Urine _____
Menstruation_____

• This child is under the care of a physician for the following conditions - Current treatment at the time of this report includes:

_____

_____

RECOMMENDATIONS AND RESTRICTIONS AT CAMP: to be completed by a **LICENSED PHYSICIAN** or **NURSE PRACTITIONER**

• 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 and management of allergies:

_____

_____

• Description of any limitations or restrictions on camp activities:

_____

_____

• Additional information for health care staff at the camp:

_____

_____

IN MY OPINION, THE ABOVE CHILD ☐ IS ☐ IS *NOT* ABLE TO PARTICIPATE IN AN ACTIVE CAMP PROGRAM

Signature of Licensed Physician_____ **Date**_____

Printed _____ **Title** _____

Address _____

Phone _(_____)_____ **Fax** _(_____)_____