



Health History & Examination Form 2012

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 Physician's Assistant 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 completed form and immunization records.** ★

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: (____) _____ Other: (____) _____

EMERGENCY CONTACT INFORMATION (OTHER THAN PRIMARY PARENT OR GUARDIAN)

Name _____ Relationship _____

Home Phone: (____) _____ Work Phone: (____) _____ Other: (____) _____

Name _____ Relationship _____

Home Phone: (____) _____ Work Phone: (____) _____ Other: (____) _____

INSURANCE INFORMATION

******YOU MUST FILL IN THE INSURANCE INFORMATION******

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

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

Name of Insured _____ 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.

Signature or parent/guardian _____ Date _____

Printed Name _____



HEALTH HISTORY

ALLERGIES (List all known)



- No known allergies.
 This camper is allergic to: Food Medicine Environment (*insect stings, hay fever, etc.*) Other

Describe below what the camper is allergic to, the reaction seen, and management of the reaction

NON-PRESCRIPTION MEDICATIONS:

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis 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 not be given (example: permission: "Benadryl", no permission: "~~Benadryl~~").

- | | | |
|---|---|---------------------------------------|
| acetaminophen (Tylenol) | Diphenhydramine antihistamine/allergy medicine (Benadryl) | 1% Hydrocortisone Cream |
| ibuprofen (Advil, Motrin) | Guaifenesin cough syrup (Robitussin) | Calamine lotion, Caladryl Cream, Aloe |
| children's ibuprofen liquid | Dextromethorphan cough syrup (Robitussin DM) | Wound Cleanser |
| Children's Tylenol (chewable or liquid) | Sore throat spray ; Generic cough drops | Antacid Tablet |
| Decongestant (Sudafed PE) Pseudoephedrine | Lice shampoo or cream (Nix or Elimite) | Sunscreen |
| Decongestant (Sudafed) | Antibiotic cream, Triple Antibiotic Ointment | Insect Repellent |
| Antihistamine/allergy medicine | | |

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

Signature or parent/guardian _____

Date _____

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
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Bedtime <input type="checkbox"/> Lunch <input type="checkbox"/> Other time: <input type="checkbox"/> Dinner		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Bedtime <input type="checkbox"/> Lunch <input type="checkbox"/> Other time: <input type="checkbox"/> Dinner		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Bedtime <input type="checkbox"/> Lunch <input type="checkbox"/> Other time: <input type="checkbox"/> Dinner		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Bedtime <input type="checkbox"/> Lunch <input type="checkbox"/> Other time: <input type="checkbox"/> Dinner		



Medications must be in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name 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:



DIETARY RESTRICTIONS (e.g. vegetarian)

The following restrictions apply to this individual:

- Does not eat pork Does not eat dairy products
 Other describe): _____



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

GENERAL QUESTIONS (Explain "yes" answers)

Does or Has your child....

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

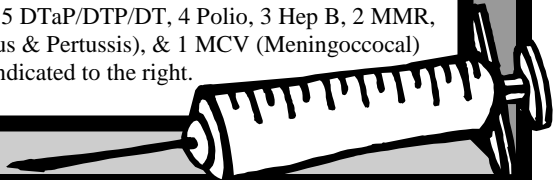
Please explain any "Yes" answers, noting the number of the question(s):

★New for 2012★

We require a copy of this camper's immunization records to date. Please attach a copy to this form.

Children in grades K-5: 5 DTaP, 4 Polio, 3 Hep B, 2 MMR, 2 Varicella, OR the date of disease(s) indicated to the right.

Children in grades 6-12: 5 DTaP/DTP/DT, 4 Polio, 3 Hep B, 2 MMR, 2 Varicella, 1 Tdap (Tetanus & Pertussis), & 1 MCV (Meningococcal) OR the date of disease(s) indicated to the right.



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.

Signature or parent/guardian _____ **Date** _____

• Use this space to provide any **additional information about the participant's behavior and physical, emotional or mental health** about which camp should be aware. (e.g. tantrums, strong dislike, sleep walks, nightmares, family change)

**HEALTH CARE RECOMMENDATIONS and
 PHYSICAL EXAM BY LICENSED PHYSICIAN
 Or Physician's Assistant**



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

- 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

 **Please include a copy of immunization records**

Signature of Licensed Physician _____ Date _____

Printed _____ Title _____

Address _____

Phone (____) _____ Fax (____) _____