



Winter: 32 Grassmere Rd., Brookline, MA, 02467 Tel: 617-325-1541 Fax: 617-325-1541
Summer: 50 Encore/Coda Lane, Sweden, ME, 04040 Tel: 207-647-3947 Fax: 207-647-3259
Email: jamie@encore-coda.com ellen@encore-coda.com
Website: encore-coda.com

May 2019

Dear parents,

Please note that the state of Maine has recently tightened it's immunization requirements for camp admissions to match existing rules for public school admissions.

The upshot of this change is that camp directors, by law, are no longer permitted to admit any child into camp for whom we do not have a complete record of immunizations.

So please be sure to include a complete record of immunizations with this health form when you send it to us. Or, if you have a bonafide religious reason why you have not had your child immunized that meets the criteria outlined in the Maine state guidelines below, a statement from you to that effect.

The Maine immunization guidelines are available in detail at: <https://www1.maine.gov/dhhs/mecdc/infectious-disease/immunization/family/documents/immunization-requirements-for-school-children.pdf>

Many thanks,

JAMIE & ELLEN



Camp Encore/Coda, Sweden, Maine 04040

Health History and Examination Form for Campers & Staff Members

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care and securing emergency treatment if required. Attendance at camp is contingent on our receiving this form, appropriately completed by camper parent/guardian (or staff member) and licensed medical personnel.

If completed before May 24th, please mail to: 32 Grassmere Rd, Brookline, MA 02467

If completed after May 24th, please mail to: 50 Encore/Coda Lane, Sweden, ME 04040 or fax to 207-647-3259

Personal Information

Name _____ Birth date _____ Age at camp _____
Last First Middle

Dates of Camp Attendance (circle one): 1st Session 2nd Session Full Season Staccato Session Gender: Male Female

Home address _____
Street address City State Zip

Parent/Guardian 1 _____ Phone _____ Email: _____

Home address _____
Street address City State Zip

Parent/Guardian 2 _____ Phone _____ Email: _____

Address _____ Phone _____
Street address City State Zip

If not available in an emergency, notify: Name _____

Relationship _____ Phone _____ Email: _____

Address _____
Street address City State Zip

Insurance Information

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

If so, indicate carrier or plan name _____

Carrier address _____ Group # _____

Name of insured _____ Relationship to participant _____

Social security number of policy holder or insurance ID number _____

Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. I hereby give permission to the physician selected by the camp 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 of parent or guardian or adult camper/staffer _____

Witness _____ Date _____

I understand and agree to abide by the restrictions placed on my camp activities.

Signature of minor or adult camper/staffer _____ Date _____

Health History

The following information must be filled in by the parent/ guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known.

Describe reaction and management of the reaction.

Medication allergies (list)

_____	_____
_____	_____
_____	_____

Food allergies (list)

_____	_____
_____	_____

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

_____	_____
_____	_____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it 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.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer:

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

Does not eat red meat

Does not eat pork

Does not eat poultry

Does not eat seafood

Does not eat eggs

Does not eat dairy products

Other (describe) _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

General Questions (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	[]	[]	17. Ever had problems with joints (e.g., knees, ankles)?	[]	[]
2. Have a chronic or recurring illness/condition?	[]	[]	18. Have an orthodontic appliance being brought to camp?	[]	[]
3. Ever been hospitalized?	[]	[]	19. Have any skin problems (e.g., itching, rash, acne)?	[]	[]
4. Ever had surgery?	[]	[]	20. Have diabetes?	[]	[]
5. Have frequent headaches?	[]	[]	21. Have asthma?	[]	[]
6. Ever had a head injury?	[]	[]	22. Had mononucleosis in the past 12 months?	[]	[]
7. Ever been knocked unconscious?	[]	[]	23. Had problems with diarrhea/constipation?	[]	[]
8. Wear glasses, contacts or protective eye wear?	[]	[]	24. Have problems with sleepwalking?	[]	[]
9. Ever had frequent ear infections?	[]	[]	25. If female, have an abnormal menstrual history?	[]	[]
10. Ever passed out during or after exercise?	[]	[]	26. Have a history of bed-wetting?	[]	[]
11. Ever been dizzy during or after exercise?	[]	[]	27. Ever had an eating disorder?	[]	[]
12. Ever had seizures?	[]	[]	28. Ever had emotional difficulties for which professional help was sought?	[]	[]
13. Ever had chest pain during or after exercise?	[]	[]			
14. Ever had high blood pressure?	[]	[]			
15. Ever been diagnosed with a heart murmur?	[]	[]			
16. Ever had back problems?	[]	[]			

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

Which of the following has the participant had?

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis

TB Mantoux Test

Date of last test _____

Result: Positive Negative

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____				
or Measles		_____	_____				
or Mumps		_____	_____				
or Rubella		_____	_____				
Haemophilus influenza B		_____	_____	_____	_____		
Hepatitis B		_____	_____	_____	_____		
Varicella (chicken pox)		_____	_____				
BCG		_____	_____				

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

and the person herein described has permission to engage in all camp activities except as noted.

Signed _____ Printed _____ Date _____

Health Care Recommendations by Licensed Medical Personnel

I have examined the above camp participant. Date of last examination _____

BP _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program.

The applicant 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

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

Description of any limitation or restriction on camp activities

Additional information for health care staff at the camp

Signature of Licensed Medical Personnel

Printed _____ Title _____

Address _____

Phone _____ Date _____

For camp use only

Screening Record

Date screened _____ Time ______am/pm

Meds received _____

Updates/additions to health history noted Yes No None required

Current health needs identified _____

Observational notes _____

Screened by _____