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**

1. Had any recent injury, illness or infectious disease? .... [ ] [ ]
2. Have a chronic or recurring illness/condition? [ ] [ ]
3. Ever been hospitalized? ....[ ] [ ]
4. Ever had surgery? ....[ ] [ ]
5. Have frequent headaches? ....[ ] [ ]
6. Ever had a head injury? ....[ ] [ ]
7. Ever been knocked unconscious? ....[ ] [ ]
8. Wear glasses, contacts or protective eye wear? ....[ ] [ ]
9. Ever had frequent ear infections? ....[ ] [ ]
10. Ever passed out during or after exercise? .. ..[ ] [ ]
11. Ever been dizzy during or after exercise? ....[ ] [ ]
12. Ever had seizures? ....[ ] [ ]
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? ....[ ] [ ]

Yes No

17. Ever had problems with joints (e.g., knees, ankles)? ....[ ] [ ]
18. Have an orthodontic appliance being brought to camp? ....[ ] [ ]
19. Have any skin problems (e.g., itching, rash, acne)? ....[ ] [ ]
20. Have diabetes? ....[ ] [ ]
21. Have asthma? ....[ ] [ ]
22. Had mononucleosis in the past 12 months? .[ ] [ ]
23. Had problems with diarrhea/constipation? ....[ ] [ ]
24. Have problems with sleepwalking? ....[ ] [ ]
25. If female, have an abnormal menstrual history? ....[ ] [ ]
26. Have a history of bed-wetting? ....[ ] [ ]
27. Ever had an eating disorder? ....[ ] [ ]
28. Ever had emotional difficulties for which ....[ ] [ ] professional help was sought? ....[ ] [ ]

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

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____

____

____

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.

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____

____

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 ______________________________