

Health History and Examination Form for Children, Youth, and Adults Attending Camps

Please mail to the address below:
TrailRidge Mountain Camp
234 Riene Lane
Swannanoa NC 28778

Name _____ Birthdate _____ Sex ____ Age ____

Custodial parent/guardian _____ Phone _____

Home Address _____ Phone _____

Business Address _____ Phone _____

Second Parent or Guardian or Emergency Contact _____

Home Address (if different from above) _____

Business Address _____ Phone _____

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|--|
| <p>Health History (Check and give approximate dates)</p> <p>_____ Frequent Ear Infections</p> <p>_____ Heart Defect/Disease</p> <p>_____ Convulsions</p> <p>_____ Diabetes</p> <p>_____ Bleeding/Clotting Disorders</p> <p>_____ Hypertension</p> <p>_____ Mononucleosis</p> <p>Diseases</p> <p>_____ Chicken Pox</p> <p>_____ Measles</p> <p>_____ Mumps</p> <p>Allergies (Dates not needed)</p> <p>_____ Hay Fever</p> <p>_____ Ivy Poisoning, etc.</p> <p>_____ Insect Stings</p> <p>_____ Penicillin</p> <p>_____ Asthma</p> <p>_____ Other (specify) _____</p> |
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Operations or serious injuries (dates) _____

Chronic or recurring illness or medical condition _____

Dietary Restrictions _____

Current medications (send with instructions) _____

Name of family physician _____ Phone _____

Name of dentist/orthodontist _____ Phone _____

Do you carry family medical/hospital insurance? Yes No

If so, indicate: Carrier _____ Policy/Group # _____

Carrier Address _____

Suggestions on health related information for camp personnel _____

For female

Has this person menstruated? ____ If not, has she been told about it? ____

Is her menstrual history normal? _____ Special consideration _____

Important — This Box Must be Completed for Attendance

I have read and understand all camp policies as stated on the "Application for Admission." If necessary, I have enclosed a description of and physical, emotional, or possible behavioral conditions that may affect my child's stay at camp. I understand that there is an inherent risk involved in many camp activities. The directors and members of TrailRidge Mountain Camp exercise extreme caution in the conduct of all camp activities; however, they do not assume responsibility for accidents or illness suffered by its campers. This health history is correct and complete as far as I know. The person herein described has permission to participate in all camp activities except as noted.

AUTHORIZATION FOR TREATMENT: I hereby give my permission to the medical personnel selected by the camp directors to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the above-named person. This completed form may be copied for trips away from camp.

Signature of parent/guardian or adult camper/staffer _____

Witness _____ Date _____

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

Signature of minor or adult camper/staffer _____ Date _____

Immunization History

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

| Vaccines | Year of Basic Immunization | Year of Last Booster |
|--|----------------------------|----------------------|
| Diphtheria Pertussis (Whooping Cough) Tetanus or DPT | 1 2 3 | 1 2 |
| Tetanus Diphtheria or TD | | |
| Tetanus | | |
| Oral Polio (Sabin) TOPV | | |
| Injectable Polio (Salk) | | |
| Measles (hard measles, red measles, rubeola) | | |
| Mumps | | |
| Rubella (German measles, 3-day measles) | | |
| Other | | |
| Tuberculin test given _____ (most recent) | | |
| Haemophilus influenza b (HIB) | | |
| Hepatitis B | | |

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant within the past two years. Date Examined _____

In my opinion, the above's condition does does not preclude his/her participation in an active camp program.

Height _____ Weight _____ Blood Pressure _____

The applicant is under the care of a physician for the following condition(s)

Current treatment (include current medications) _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Does applicant have epilepsy? _____ Does applicant have diabetes? _____

Any treatment to be continued at camp _____

Any medication to be administered at camp (specific doses) _____

Any medically prescribed meal plan or dietary restrictions _____

Any allergies (food, drug, plants, insects, etc.) _____

Activities to be encouraged or limited _____

Additional health information _____

Licensed Physician's Signature _____

Address _____ Phone _____

Street address City State Zip

Date of Form Completion _____ By _____

Initial if completed by nurse or physician's assistant