

RESIDENT CAMP ADULT HEALTH EXAMINATION RECORD

Name (Last, First, Initial)		Email		
Address		City	State	Zip
Home Phone (____) _____		Date of Birth		Sex Female Male
Cell Phone (____) _____				
Work Phone (____) _____				
Emergency Contact Person & Relationship		Home Phone (____) _____		
		Cell Phone (____) _____		
		Work Phone (____) _____		

ALLERGIES

Animals
 Food
 Insect Stings
 Medicine/Drugs
 Plants
 Seasonal
 Other

Describe reaction and management of this reaction: _____

MEDICATIONS

Please list ALL medications (including over-the-counter non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle.: _____

NUTRITION

Our expectation is that staff set an example for campers by eating the provided menu. The camp kitchen provides meatless meal options. They can work effectively with some medically prescribed diets but do not cater to individual preferences.

_____ I eat a regular, varied diet.

_____ I have the following dietary restrictions _____

CHRONIC CONCERNS

- | | | |
|--|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Sleep problem |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Dysmenorrhea |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Surgery history | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Back pain or injury | <input type="checkbox"/> Knee or ankle weakness | <input type="checkbox"/> Other: _____ |

Provide information about supportive healthcare needed for each marked item:

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

Photocopy of front and back of all health insurance cards must be attached to this form.

This health history is correct and complete as far as I know. I am in good health and able to participate in all camp activities, except as noted by the examining physician and me. I agree to the release of any records necessary for insurance purposes. The first and fourth page of this form may be photocopied for trips out of camp.

Signature of Applicant _____ Date _____

Sign Here

Office Use Only

Office Use Only	
Med HX 6 th months	
Signature	
PE 2 years	
Immuno HX	
MD Stamp	
MD Signature	
Insurance	

Open booklet, there are questions inside!

GENERAL PHYSICAL HISTORY

- 1. Have you ever been hospitalized? 0 Yes 0 No
Have you ever had surgery? 0 Yes 0 No
 - 2. Have you ever passed out during or after exercise? 0 Yes 0 No
Have you ever been dizzy during or after exercise? 0 Yes 0 No
Have you ever had chest pain during or after exercise? 0 Yes 0 No
Do you tire more quickly than your friends during exercise? 0 Yes 0 No
Have you ever had high blood pressure? 0 Yes 0 No
Have you ever been told that you had a heart murmur? 0 Yes 0 No
Have you ever had racing of you heart or skipped heartbeats? 0 Yes 0 No
 - 3. Do you have skin problems (itching, rashes, acne)? 0 Yes 0 No
 - 4. Have you ever been knocked out or unconscious? 0 Yes 0 No
Have you ever had a seizure? 0 Yes 0 No
Have you ever had a pinched nerve? 0 Yes 0 No
 - 5. Have you ever had a heat or muscle cramps? 0 Yes 0 No
Have you ever been dizzy or passed out in the heat? 0 Yes 0 No
 - 6. Have you ever sprained, strained, dislocated, fracture, broken or had repeated swelling or other injuries to any of your body parts? If so, where? _____ 0 Yes 0 No
Do you need assistance or feel discomfort when lifting and carrying 30 pounds at least ten times? 0 Yes 0 No
 - 7. Have you had mononucleosis in the past nine months? 0 Yes 0 No
 - 8. Do you have a hearing problem? 0 Yes 0 No
Do you have a vision (sight) problem? 0 Yes 0 No
Do you wear glasses or contacts or use protective eye wear? 0 Yes 0 No
 - 9. Do you smoke and/or use other tobacco products? 0 Yes 0 No
 - 10. Do you typically make noise while sleeping (i.e., snore, talk in sleep, etc.)? 0 Yes 0 No
 - 11. Do you have any piercings? If so, where? _____ 0 Yes 0 No
Do you have any tattoos? If so, where? _____ 0 Yes 0 No
- NOTE: NEW TATOOS AND PIERCINGS ARE NOT ALLOWED AT CAMP!
- 12. Do you have any problems with your teeth? 0 Yes 0 No
 - 13. Have you been in countries other than the USA in the past nine months? Is so, where and when? 0 Yes 0 No
-
- 14. For women: Do you have a menstrual problem (pain, irregularity, etc.)? 0 Yes 0 No

Explain and/or provide more detail about the General Physical Health questions to which you responded “yes.”

MENTAL & EMOTIONAL HEALTH INFORMATION

- A. Have you been diagnosed with attention deficit disorder (ADD) or AD/HD? 0 Yes 0 No
- B. Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder? 0 Yes 0 No
- C. Do you have an eating disorder? Type: _____ 0 Yes 0 No
- D. Do you have a learning disability? Type: _____ 0 Yes 0 No
- E. Do you have an emotional health concern? 0 Yes 0 No
- F. During the past year, have you seen a professional about mental/emotional concerns? 0 Yes 0 No

If “yes” to any question in this section, attach a statement that:

- Describes the concern and your management plan for addressing it while working at camp; and
- Describes the support needed from your work supervisor to compliment your plan.

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Name _____ Date of Birth _____

This section to be filled in by Licensed Medical Personnel

I examined this individual on _____. (Within 24 months of camp attendance.)

BP _____ Pulse _____ 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:

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:

Record of Immunizations

Immunization	Date Series Completed Or Date of Titer
DPT (Diphtheria, Tetanus, Pertussis)	
Hepatitis A	
Hepatitis B	
Meningitis	
MMR (Mumps, Measles, Rubella)	
Pneumococcal	
Polio	
Tetanus (within 10 years)	
Varicella (Chicken Pox)	
Tuberculin Test Type _____	Year _____
	Results _____

If disease, put D and year.
A TETANUS SHOT GIVEN WITHIN 10 YEARS IS REQUIRED.

Signature of Licensed Medical Personnel _____ **Date** _____

STAMP which must provide:
Name, title, address, phone

