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For Office Use

Year ______

Cabin or Group ______

Name ______

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

FM 08

Developed and approved by
American Camping Associations
American Academy of Pediatrics

Dates of Camp Attendance ______

Please return no later than 2 weeks before camp date to:
Coyote Hill Mountain Bike Camp
P. O. Box 212
Bradford, VT 05033

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. This form, except for the "Health Recommendations of Licensed Medical Personnel," to be filled in by parents/guardians of minors or by adults themselves.

Name ______ (Last) ______ (First) ______ (Middle) Birth date ______ Age at camp ______

Home address ______ (Street address) ______ (City) ______ (State) ______ (Zip)

Social security number of participant ______ Gender: ☐ Male ☐ Female

email ______

Custodial parent/guardian ______ Phone ______

Home address (if different from above) ______ (Street address) ______ (City) ______ (State) ______ (Zip)

Business address ______ (Street address) ______ (City) ______ (State) ______ (Zip) Phone ______

Second parent or guardian or emergency contact ______

Address ______ (Street address) ______ (City) ______ (State) ______ (Zip) Phone ______

Business address ______ Phone ______

If not available in an emergency, notify:

Name ______

Relationship ______ Phone ______

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 ______ Group # ______

Carrier address ______

Name of insured ______ Relationship to participant ______

Social security number of policy holder or insurance ID number ______

Important — These boxes must be complete for attendance*

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. In the event I cannot be reached in an emergency, 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 also understand and agree to abide by the restrictions placed on my camp activities.

Signature of minor or adult camper/staffer ______ Date ______

**If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

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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 eggs

☐ Does not eat poultry ☐ Does not eat seafood ☐ Does not eat dairy products

☐ Other (describe) ______________________________

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?	☐	☐
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.

____

____

____

____

____

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 ________________________

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, 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 ____________________

____