



# Pilgrim Heights

Camp Retreat Center  
2010 Summer Camp Health Form

**PLEASE NOTE**

**A complete, signed 2010 Health Form is required for ALL participants.**

Camper Name (Last, First, Initial)	Name & Relationship of parent/guardian completing this form			Daytime Phone		
Address (Street & Number)	City or Town	State	Zip Code	Date of Birth	Age	Grade

**EMERGENCY CONTACT INFORMATION**

Relationship Key: M = Mother F = Father SM = Stepmother SF = Stepfather GP = Grandparent O = Other

NAME	RELATIONSHIP	DAYTIME PHONE	EVENING PHONE	CELL PHONE

Are there any legal custodial issues we should be aware of?  No  Yes If yes, please explain: \_\_\_\_\_

**INSURANCE INFORMATION (Please attach a copy of your medical insurance card)**

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

If yes, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

Carrier address \_\_\_\_\_

Name of insured \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

Social security number of policy holder or insurance ID number \_\_\_\_\_

**HEALTH HISTORY – Please check all that apply.**

CRONIC / RECURRING ILLNESS	OTHER HEALTH CONDITIONS		
<input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> Ear Infection <input type="checkbox"/> Heart defect / disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Kidney disease <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Musculoskeletal disorders <input type="checkbox"/> Seizures / Epilepsy <input type="checkbox"/> Sinusitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other (Please Specify) _____	<input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Bedwetting <input type="checkbox"/> Behavioral disturbances <input type="checkbox"/> Constipation <input type="checkbox"/> Depression <input type="checkbox"/> Diarrhea <input type="checkbox"/> Emotional disturbances <input type="checkbox"/> Fainting <input type="checkbox"/> Frequent colds <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Frequent sore throats <input type="checkbox"/> Frequent stomach aches	<input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Menstrual cramps <input type="checkbox"/> Motion sickness <input type="checkbox"/> Night terrors <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Pediculosis (lice) <input type="checkbox"/> Sleepwalking <input type="checkbox"/> Wears contacts/glasses <input type="checkbox"/> Wears orthodontic device <input type="checkbox"/> Others (Specify) _____	<p><b>In the last year, has the camper had:</b></p> <input type="checkbox"/> an injury/illness requiring medical attention <input type="checkbox"/> a surgical operation or fracture <input type="checkbox"/> restrictions from participation in P.E. class <input type="checkbox"/> an illness lasting longer than 5 days <input type="checkbox"/> hospital treatment <input type="checkbox"/> exposure to a contagious disease <p><b>Is participant currently:</b></p> <input type="checkbox"/> receiving psychological counseling <input type="checkbox"/> under a physician's care <input type="checkbox"/> restricted from physical activity <input type="checkbox"/> taking prescription medication <i>(Complete reverse side)</i> <input type="checkbox"/> taking over the counter medication <i>(Complete reverse side)</i> <p><b>Please explain</b> any items checked above. Give dates and include any information that would be helpful to camp staff in relation to these health conditions. Add an additional sheet if needed.</p> <p>_____</p> <p>_____</p> <p>_____</p>
<b>OTHER INFORMATION</b>			
Has your daughter been taught about menstruation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Has your daughter begun menstruation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Specify any special dietary regimen to be followed: _____ _____ Specify activities to be encouraged: _____ Specify activities to be restricted: _____ List necessary adaptations or limitations: _____ _____			

**ALLERGIES**

List all known (medication, food, insect stings, hay fever, etc.)

Describe reaction & management of the reaction

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**\*\*Attach additional pages for more allergies\*\***

The following medications are provided at camp. They will be administered under the designated health supervisor's supervision; dosage as appropriate for weight and/or age. We encourage your permission to use them by placing an "X" in the box beside each.

- |  |                                      |  |  |
|--|--------------------------------------|--|--|
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Antacid     | <input type="checkbox"/> Anti-diarrheals | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Decongestant  | <input type="checkbox"/> Expectorant | <input type="checkbox"/> Diphenhydramine | <input type="checkbox"/> Ibuprofen     |

**PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS BROUGHT FROM HOME (Please complete below)**

MEDICATION	CONDITION TREATED	DOSAGE	TIME OF DAY	TAKEN WITH FOOD?
			<input type="checkbox"/> B-fast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> As needed <input type="checkbox"/> Other	
			<input type="checkbox"/> B-fast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> As needed <input type="checkbox"/> Other	
			<input type="checkbox"/> B-fast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> As needed <input type="checkbox"/> Other	
			<input type="checkbox"/> B-fast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> As needed <input type="checkbox"/> Other	

**RECORD OF IMMUNIZATION**

	Date of Last Immunization		Date of Last Immunization
DTaP	_____	Diphtheria	_____
Pertussis (Whooping Cough)	_____	Tetanus (within last 10 yrs)	_____
Td	_____	Oral polio / IPV	_____
Measles	_____	Mumps	_____
Rubella	_____	Hib	_____
Hep B	_____	Tuberculin Test	Yr last given _____ Result _____

**HEALTH STATEMENT**

This health record, including the allergy and medicine information on this form is complete and accurate. My camper has my permission to engaged in all prescribed activities, including strenuous activities such as hiking, swimming, climbing hills, except as noted by me and the examining physician. I give my permission for the camp staff to obtain in-camp or out-of-camp medical treatment for my camper should the need arise while they are at camp. In case of emergency, if none of the contacts on the opposite side of this form can be contacted, I consent to treatment for my camper under the supervision the camp staff. If my camper is out-of-camp on a trip, I understand I will not be contacted before medical treatment is given.

**HEALTH INFORMATION PRIVACY STATEMENT**

This health form is for health care concerns at Pilgrim Heights camp sessions only. All records will be handled by staff / volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the Director/Dean at each camp. Minimal necessary information will be shared with other staff / volunteers in order to provide adequate participant safety and health care. The health form will be retained by Pilgrim Heights Camp and Retreat Center until it is destroyed. All forms / records with noted treatment will be retained for seven years past the age of maturity of the participant. I have read the above procedures for handling the health form and agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

**SIGNATURE OF PARENT OR GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

\*\*\*\*\***PHYSICAL EXAMINATION**\*\*\*\*\*

**NOTE TO PHYSICIAN:** Required for any individual participant attending program.  
 Adult program participants do not need to complete the following section.

**DATE OF HEALTH EXAMINATION:** \_\_\_\_\_

- |                 |                       |
|-----------------|-----------------------|
| Nose _____      | Throat _____          |
| Teeth _____     | Heart _____           |
| Lungs _____     | Abdomen _____         |
| Genitalia _____ | Hernia _____          |
| Skin _____      | Musculoskeletal _____ |

General Physical and emotional status \_\_\_\_\_  
 Urinalysis\* \_\_\_\_\_ HGB\* \_\_\_\_\_  
 Other Notes:  
 \_\_\_\_\_  
 \_\_\_\_\_

Physician's comments and/or recommendations.  
 Give details or indicate management or significant illnesses.  
 \_\_\_\_\_  
 \_\_\_\_\_

\*Not required for every health exam.

Height \_\_\_\_\_ Weight \_\_\_\_\_ B.P. \_\_\_\_\_

Appearance / Nutrition \_\_\_\_\_

	W/OUT GLASSES	W/GLASSES
<b>EYES</b>	R 20/____ L 20/____	R 20/____ L 20/____

<b>EARS</b>	Hearing Right _____	Hearing Left _____
-------------	---------------------	--------------------

- Which of the following, if any, has the patient had?
- |                                    |   |                                |
|------------------------------------|---|--------------------------------|
| <input type="checkbox"/> Measles   | <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> German Measles |                                |

This person is in satisfactory condition and may engage in all usual activities, except as noted.

**Licensed physician's name:**  
 \_\_\_\_\_

**Licensed physician's signature:**  
 \_\_\_\_\_

Address \_\_\_\_\_  
 Phone \_\_\_\_\_ Date \_\_\_\_\_