



Pilgrim Heights

Camp Retreat Center
2012 Summer Camp Health Form

PLEASE NOTE

A complete, signed 2012 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		In the last year, has the camper had: <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 then 5 days <input type="checkbox"/> hospital treatment <input type="checkbox"/> exposure to a contagious disease Is participant currently: <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> Please explain 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. _____ _____ _____
<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>OTHER INFORMATION</p> <p>Has your daughter been taught about menstruation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Has your daughter begun menstruation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Specify any special dietary regimen to be followed: _____</p> <p>Specify activities to be encouraged: _____</p> <p>Specify activities to be restricted: _____</p> <p>List necessary adaptations or limitations: _____</p>			

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 engage 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. In case of emergency, medical treatment will be given under the supervision the camp staff; and emergency contacts on the opposite side of this form can be contacted as soon as possible.

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: Must be within the last 2 years.

Required for any individual participant attending program. However, adult program participants do not need to complete the following section.

<p>DATE OF HEALTH EXAMINATION: _____</p> <p>Nose _____ Throat _____</p> <p>Teeth _____ Heart _____</p> <p>Lungs _____ Abdomen _____</p> <p>Genitalia _____ Hernia _____</p> <p>Skin _____ Musculoskeletal _____</p> <p>General Physical and emotional status _____</p> <p>Urinalysis* _____ HGB* _____</p> <p>Other Notes:</p> <p>_____</p> <p>_____</p> <p>Physician's comments and/or recommendations. Give details or indicate management or significant illnesses.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>*Not required for every health exam.</p>	<p>Height _____ Weight _____ B.P. _____</p> <p>Appearance / Nutrition _____</p> <table border="1" style="width: 100%;"> <thead> <tr> <th></th> <th>W/OUT GLASSES</th> <th>W/GLASSES</th> </tr> </thead> <tbody> <tr> <td>EYES</td> <td>R 20/____ L 20/____</td> <td>R 20/____ L 20/____</td> </tr> </tbody> </table> <table border="1" style="width: 100%;"> <tr> <td>EARS</td> <td>Hearing Right _____ Hearing Left _____</td> </tr> </table> <p>Which of the following, if any, has the patient had?</p> <p><input type="checkbox"/> Measles <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Hepatitis <input type="checkbox"/> German Measles</p> <p>This person is in satisfactory condition and may engage in all usual activities, except as noted.</p> <p>Licensed physician's name:</p> <p>_____</p> <p>Licensed physician's signature:</p> <p>_____</p> <p>Address _____</p> <p>Phone _____ Date _____</p>		W/OUT GLASSES	W/GLASSES	EYES	R 20/____ L 20/____	R 20/____ L 20/____	EARS	Hearing Right _____ Hearing Left _____
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