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FOR CAMP USE ONLY	
YEAR	______
UNIT	______
EXPIRES	______
ALLERGIES	☐
RESTRICTIONS	☐
MEDICATIONS	☐

Health Form

☐ Camper
☐ Staff
☐ Volunteer

IMPORTANT – THIS FORM MUST BE FILLED OUT COMPLETELY IN ORDER TO ATTEND CAMP. BRING SIGNED AND NOTARIZED FORM WITH YOU ON CHECK-IN DAY. IT'S YOUR TICKET TO CAMP.

Section I – Important Information – To be filled out by Parent or Guardian

Name____
Last First Middle

Gender: ☐ Male ☐ Female Birth date____/____/____ Age______Social Security # ____________________

Home Address____
Street City State Zip

Mother/Guardian______________________________Home Phone____________________

Cell Phone: ______________________________Work Phone____________________

Father/Guardian______________________________Home Phone____________________

Cell Phone: ______________________________Work Phone____________________

Child lives with: ☐ Mother ☐ Father ☐ Other(Specify)______________________________

Home Phone______________________________Work Phone____________________

Additional Emergency Contact
In case we can't reach YOU______________________________Relationship____________________

Home Phone______________________________Work Phone____________________

Family Physician Name______________________________Phone____________________

Dentist/Orthodontist Name______________________________Phone____________________

The following person is legally restricted from seeing this camper: ______________________________

Relationship: ______________________________

Please inform us in writing of any travel plans you have during your child's stay at Dogwood Acres. Please attach phone numbers, local relative names and numbers, and/or any other information that would assist us in contacting you in case of emergency. Thank you.

Section II – Insurance Information – Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name______________________________Group #____________________

Insurance Company Phone Number____________________ Name of Insured____________________

Policy Holder's SS# or Insurance ID #____________________ Relationship to participant____________________

Address for Claims____

If possible, please attach a copy of both sides of your insurance card to this form. Thank you.

Section III – Health History – To Be Filled out By Parent/Guardian

Allergies: ☐ Poison Ivy ☐ Hay Fever ☐ Insect Stings ☐ Penicillin/Other Drugs ☐ Food ☐ Other____________________

Please list and describe allergies, reactions, and treatment below:

____

____

____

Physical activities at camp to be limited or encouraged____

____

Dietary modifications____

For females, has she menstruated? ☐ Yes ☐ No If not, has she been told about it? ☐ Yes ☐ No

List all medications, including over-the-counter drugs, currently taken by the camper ☐ This camper takes no medications

Medication	Dosage	Reason for taking

All medications ***(including non-prescription and over-the-counter drugs, inhalers, vitamins and ointments) will be registered with the Camp Health Center upon check-in. Medications must be in their original labeled container that identifies the child's name, prescribing physician (if a prescription drug), name of the medication, dosage, and frequency of administration. Please bring enough medication to last the entire time at camp. Thank you.***

Has the participant ever / does currently / is prone to:

	YES	NO
1. Recent injury, illness or infectious disease……………	☐	☐
2. Chronic or recurring illness/condition……………………..	☐	☐
3. Been hospitalized…………………………………………..	☐	☐
4. Had surgery………………………………………………..	☐	☐
5. Fractures………………………………………………….....	☐	☐
6. Frequent headaches……………………………………..	☐	☐
7. Had a head injury…………………………………………..	☐	☐
8. Been knocked unconscious……………………………….	☐	☐
9. Wear glasses, contacts or protective eyewear……...…	☐	☐
10. Ear infections………………………………………….....	☐	☐
11. Passed out during or after exercise……………………...	☐	☐
12. Ever been dizzy during or after exercise………………..	☐	☐
13. Seizures…………………………………………………..	☐	☐
14. Chest pain during or after exercise…………………….	☐	☐
15. High blood pressure……………………………………..	☐	☐
16. Heart murmur…………………………………………….	☐	☐
17. Had psychiatric counseling………………………………	☐	☐
18. Back problems…………………………………………...	☐	☐
19. Joint problems (e.g. knees, ankles)……………………...	☐	☐
20. Have an orthodontic appliance being brought to camp..	☐	☐
21. Skin problems (e.g. itching, rash, acne)…………………	☐	☐
22. Diabetes…………………………………………………..	☐	☐
23. Asthma……………………………………………………	☐	☐
24. Had mononucleosis in the past 12 months……………..	☐	☐
25. Had problems with diarrhea/constipation………………..	☐	☐
26. If female, have an abnormal menstrual history………	☐	☐
27. Nightmares / Night terrors………………………………	☐	☐
28. Sleepwalks………………………………………………..	☐	☐
29. Ever had an eating disorder…………………………….	☐	☐
30. Requires and/or wears a Medic Alert ID………………..	☐	☐
31. Homesickness……………………………………………	☐	☐
32. Stomachaches……………………………………………	☐	☐
33. Have a history of bedwetting……………………………	☐	☐

Please explain any "yes" answers, noting the number of the questions. Attach extra page if necessary:

____

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____

____

____

____

Immunization History – This information will assist hospital staff in the event of an emergency. If possible, simply attach a copy of your child's shot records. ***It is OKAY if you do not know the dates of your child's immunizations, he or she may still participate in camp programs.***

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DPT	________	________	________	________	________	________
Td	________	________	________	________	________	________
Tetanus	________	________	________	________	________	________
Polio	________	________	________	________	________	
MMR	________	________	________	________	________	________
Haemophilius Influenza B	________	________	________	________		
Hepatitis B	________	________	________			
Varicella (chicken pox)	________	________				
BCG	________					

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken Pox
- ☐ German Measles
- ☐ Mumps
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Rheumatic Fever

Date of Most Recent TB test ________________

Section IV – Medical Authorization and Waiver – Must be signed by Parent or Guardian and notarized.

I give permission for my child to engage in all prescribed camp activities, except as noted. I will make sure my child understands and agrees to abide by the restrictions noted on camp activities. I am aware that my child may be transported by bus or other vehicles authorized by Dogwood Acres for approved trips out of camp/off-site activities. This completed form may be photocopied for trips out of camp/off-site.

I expect that my child will be well supervised during camp activities. I realize that individuals at camp can injure themselves at camp without fault on the part of Dogwood Acres personnel. I release Dogwood Acres from responsibility for injury to my child.

If my child is to take medication, I will instruct my child to take responsibility for going to the Health Center at scheduled times for this purpose.

I hereby give permission to medical personnel selected by the Camp Director to order X-rays, routine tests, treatments; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child (or me as staff/ volunteer).

In case of emergency, I understand that every effort will be made to contact parents or guardians of the camper. In the event that I cannot be reached, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure treatment for, and to order injection, anesthesia or surgery for my child as named herein. I hereby authorize the Camp Director and staff to act for me, and on my behalf, according to their best judgment, in any emergency requiring medical attention to be administered to my child, until such time as I may be contacted. I give permission for the Dogwood Acres Health Center Coordinator, or other designated staff member, to administer authorized medication and/or first aid and/or emergency treatment to my child during the camp/program session.

I understand that primary health and accident insurance protection are my responsibility.

I represent and agree that my child is in good health and physical condition and able to fully participate in the entire camp program.

I have indicated any special health, medical or physical condition, including any required medication and activity limitations which should be known to the camp staff, director, emergency medical personnel, doctors or nurses.

In signing this application, I hereby certify that I have read and understand the above statements and attest that the information that I have supplied on this form is correct to best of my knowledge.

Signature of Parent/Guardian (or Adult Staff/Volunteer) X____

Parent/Guardian Name Printed____Date____________________

Sworn to and subscribed before me this ________ day of __________________ , in the year ___________

Notary Public: ____

Commission No. __________________________ My Commission Expires ________________________

Section V – Examination – To be completed by a licensed physician

This child has had a physical exam on the following date: __________ (MONTH) ______ (DAY) ________ (YEAR)   Height_______ Weight_______

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.   Blood Pressure_____________

The applicant is under the care of a physician for the following conditions:

____

____

Current treatment at the time of this report includes:

____

____

Medications to be administered at camp (name, dosage, frequency)

____

____

Known Allergies:

____

____

Dietary Restrictions:

____

____

Activity Restrictions:

____

____

Additional Information for health care staff at Dogwood Acres

____

____

Signature of Licensed Physician X______________________________________ **Date**____________________

Printed Name:____ **Phone**___________________

Address:____

If form completed by Nurse or Physician's Assistant, please print name & title_______________________________

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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____

____

Screened By____

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