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FOR CAMP USE ONLY	YEAR _____
	UNIT _____
	EXPIRES _____
	ALLERGIES <input type="checkbox"/>
	RESTRICTIONS <input type="checkbox"/>
	MEDICATIONS <input type="checkbox"/>

Health Form

- Camper
- Staff
- Volunteer

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.

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

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

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	Which of the following has the participant had?
DPT	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Measles <input type="checkbox"/> Chicken Pox <input type="checkbox"/> German Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Rheumatic Fever
Td	_____	_____	_____	_____	_____	_____	
Tetanus	_____	_____	_____	_____	_____	_____	
Polio	_____	_____	_____	_____	_____	_____	
MMR	_____	_____	_____	_____	_____	_____	
Haemophilus Influenza B	_____	_____	_____	_____	_____	_____	
Hepatitis B	_____	_____	_____	_____	_____	_____	
Varicella (chicken pox)	_____	_____	_____	_____	_____	_____	
BCG	_____	_____	_____	_____	_____	_____	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: _____ Height _____ Weight _____
MONTH DAY YEAR

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 _____

FOR CAMP USE ONLY	SCREENING RECORD	Date Screened _____	Time _____	AM PM
	Meds Received _____			
	Updates/additions to health history noted	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> None Required
	Current Health Needs Identified _____			
	Observational Notes _____			
	Screened By _____			

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