

Journey's End Farm Camp

364 Sterling Road, Newfoundland, PA 18445 T: 570.689.3911

Health History and Examination Form

Year: 2012 Session: ____

Name _____ Birth Date _____ Age at Camp _____ Gender _____
Last First Middle

Home Address _____
Street City State Zip

Custodial Parent/Guardian _____ Home Phone _____

Cell _____ Business Phone _____

Second Parent/Guardian _____ Home Phone _____

Cell _____ Business Phone _____

Address _____
Street City State Zip

Emergency Contact _____ Phone _____

Relationship _____ Address _____
Street City State Zip

Insurance Information

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

If so, indicate carrier or plan name _____ Group # _____

Name of Primary Insured: _____

D.O.B. of Primary Insured: _____

 Please attach photocopy of health insurance card.

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp 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/Guardian or adult camper/staff _____

Printed Name _____ Date _____

Health History

The parent/guardian, or adult camper or staff member must fill in the following information. The intent of the information is to provide camp health care personnel the background to provide appropriate care. Any changes to this form should be provided to camp health personnel upon arrival in camp. Please provide complete information so that the camp can be aware of your needs.

ALLERGIES: List all Known

Medication allergies

Describe reaction and management of the reaction.

Food allergies

Other Allergies

MEDICATIONS

Please list ALL medications, even over-the-counter or nonprescription drugs, including Tylenol, Benadryl, etc. that may be taken, vitamins and homeopathic medications. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

- This person takes NO medications on a routine basis
- This person takes medications as follows

Med#1	Reason	Dosage	Time taken
Med#2	Reason	Dosage	Time taken
Med#3	Reason	Dosage	Time taken
Med#4	Reason	Dosage	Time taken

This person may take the following medications as needed.

- Tylenol
- Ibuprofen
- Benadryl
- Pepto-Bismol
- Other _____

DIETARY RESTRICTIONS

- 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) _____

PHYSICAL RESTRICTIONS

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.

General Questions (Explain "yes" answers.)

Has/does the participant:	Yes	No	Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	13. Shortness of breath with exercise?	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	14. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever had back problems?	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had joint problems or broken bones?	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have any skin problems?	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have diabetes?	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have asthma?	<input type="checkbox"/>
8. Wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	20. Had mononucleosis in the past 12 months?	<input type="checkbox"/>
9. Ever had frequent ear infections, colds or bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have problems sleepwalking?	<input type="checkbox"/>
10. Ever been dizzy/passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	22. Have a history of bedwetting?	<input type="checkbox"/>
11. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	23. Ever had an eating disorder?	<input type="checkbox"/>
12. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	24. Ever had homesickness or emotional issues?	<input type="checkbox"/>

Please explain "yes" answers, noting the number of the question and elaborate on any additional medical conditions, chronic or recurrent illnesses.

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

Please give dates of immunizations for:

Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____
Polio	_____	_____	_____	_____
MMR	_____	_____	_____	_____
or measles	_____	_____	_____	_____
or Mumps	_____	_____	_____	_____
or Rubella	_____	_____	_____	_____
Haemophilis influenza	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____

TB Manloux Test Date of last test _____
 Result: Positive Negative

Name of Family Physician _____ Phone _____
 Address _____

Health Care Recommendations by Physician:

I examined this individual on _____ BP _____ Wt. _____ Ht. _____

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

Restriction/Recommendations: _____

Signature of Physician: _____ Date _____

Screening Record: For Camp Use Only Date _____ Time _____

Meds received _____

Updates/additions to Health History _____

Screened by _____