



**GENERAL HEALTH QUESTIONS**

Has/does the participant:

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Had <b>recent</b> injury, illness or diseases? .....	<input type="checkbox"/>	<input type="checkbox"/>	Have <b>asthma</b> ? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have a <b>chronic</b> or recurring illness/condition? ...	<input type="checkbox"/>	<input type="checkbox"/>	Had <b>mononucleosis</b> in the past 12 months? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have frequent <b>headaches</b> ? .....	<input type="checkbox"/>	<input type="checkbox"/>	If female, have abnormal <b>menstrual</b> history?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have <b>diabetes</b> ? .....	<input type="checkbox"/>	<input type="checkbox"/>	Ever had an <b>eating</b> disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers, noting the **key word** in the question (use additional paper if necessary).

**MEDICATION**

Please list **ALL** medications being taken by camper, including over-the-counter or nonprescription drugs. Bring enough medication to last the entire time at camp. **Keep ALL medications in their original packaging/bottle** with clear dosage and frequency instructions, name of medication, and prescribing physician if a prescription drug.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

*Attach additional pages for more medications if needed.*  
*Also, please list meds taken during school year not taken during the summer.*

<p><b>Infectious Disease</b></p> <p><input type="checkbox"/> No exposures in last three weeks</p> <p>Exposed to:</p> <p>    ___ Chicken pox      ___ Measles</p> <p>    ___ Mumps            ___ Hepatitis, type ___</p> <p>    ___ Rubella</p> <p>If exposed, has camper had disease previously or been immunized against it?</p> <p><input type="checkbox"/> <b>Yes, specify</b> _____ <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unknown</b></p>	<table border="0"> <tr> <td style="text-align: left;"><b>Immunization Screen</b></td> <td align="center"><b>Yes</b></td> <td align="center"><b>No</b></td> <td align="center"><b>Unknown</b></td> </tr> <tr> <td>Influenza (within last year)</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Pneumovax (within last 5 years)</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Tetanus (within last 10 years)</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Hepatitis B series (completed)</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> </table>	<b>Immunization Screen</b>	<b>Yes</b>	<b>No</b>	<b>Unknown</b>	Influenza (within last year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumovax (within last 5 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus (within last 10 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B series (completed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Immunization Screen</b>	<b>Yes</b>	<b>No</b>	<b>Unknown</b>																		
Influenza (within last year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																		
Pneumovax (within last 5 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																		
Tetanus (within last 10 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																		
Hepatitis B series (completed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																		

**INSURANCE INFORMATION**

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

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

**Health Care Recommendations by Licensed Medical Personnel**

**PLEASE NOTE:** A SPECIAL VISIT TO YOUR PHYSICIAN IS **NOT** NECESSARILY REQUIRED. YOUR PHYSICIAN SHOULD SIGN THIS FORM, VERIFYING A PHYSICAL EXAM **WITHIN 24 MONTHS OF YOUR CAMP**.

I examined this individual on \_\_\_\_\_ (date). Requirements specify exams occur within 24 months of camp attendance. A new exam may not necessarily be required for camp attendance.

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

The applicant is under the care of a physician for the following condition(s).

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

Physician or other Medical Professional Certification (signature & printed name, credentials, and complete address below):

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax #: \_\_\_\_\_