

REQUIRED MEDICAL HISTORY
 (Parent or Legal Guardian to Complete)

Please Check One: Returning Camper New Camper Returning Staff New Staff

Session: _____

Camper Name _____ **Date of Birth** _____
Address _____ **Phone#:** _____

Emergency Notification:

With whom does child reside and what is / are his / her relationship(s) with the child? _____
 Parent 1 Name _____ Phone: Home _____ Work _____ Cell _____
 Parent 2 Name _____ Phone: Home _____ Work _____ Cell _____

Person to contact in an emergency if parents are unavailable:

Name: _____ Phone: Home _____ Work _____ Cell _____
 Physician: _____ Phone _____
 Dentist/Orthodontist: _____ Phone _____

Emergency Medical Information (check yes or no)

Yes ___ No ___ Allergy to a medicine, food, plant, animal, or insect	Yes ___ No ___ Seizure Disorder
Yes ___ No ___ Do you have an epinephrine pen?	Yes ___ No ___ Diabetes
Yes ___ No ___ Any condition that requires special care, medication or diet	Yes ___ No ___ Heart Trouble
Yes ___ No ___ Asthma	Yes ___ No ___ Bleeding Disorder
Yes ___ No ___ Contact Lenses	Yes ___ No ___ Dentures
	Yes ___ No ___ Bonded Teeth

Explain any of the above: _____

Medical History (check yes or no)

	<u>Yes</u>	<u>No</u>	<u>Date</u>	<u>Details</u>
Serious illness	_____	_____	_____	_____
Serious injury	_____	_____	_____	_____

Does your child have frequent: (circle yes or no)

Y / N Eye Infections Y / N Respiratory Infections
 Y / N Ear Infections Y / N Urinary Tract Infections
 Y / N Throat Infections Y / N Vaginal Infections

Does your child have: (circle yes or no)

Y / N Heart Murmur Y / N Menstrual Problems
 Y / N Rheumatic Fever Y / N Hernia
 Y / N Stomach/Intestinal Problems Y / N Back or Joint Pains

Explain any of the above: _____

Has this person had Chicken Pox? Yes No If yes, when? Date _____
 Has this person had Mumps? Yes No If yes, when? Date _____
 Has this person been exposed to a contagious disease within the past three weeks? _____
 Has this person had lice in the past six months? _____
 If applicable, has this person started menstruation? Yes No Has she been told about menstruation? Yes No
 Does this person take any medication on a regular basis? Yes _____ No _____
 Explain: _____

To the best of my knowledge, the above information is correct. I give my child permission to participate in all camp activities and trips.

In the event of accident or illness, I authorize the Camp to institute and obtain medical care.

**** In the event of a communicable disease outbreak, I understand this person will be excluded from camp if not fully immunized.**

DATE _____ **SIGNATURE (parent or legal guardian)** _____

MEDICAL EVALUATION

(To be completed by physician)

Name _____ Date of Birth _____ has had a complete history and physical exam on _____
Month/Day/Year Month/Day/Year

Screening / Test Results

Height:	BMI:	Vision/Type of Screening
Weight:	<input type="checkbox"/> Normal	With Glasses R 20 / L 20 /
Blood Pressure:	<input type="checkbox"/> Abnormal	With out Glasses R 20 / L 20 /
Pulse:	Min:	
HCT/Hgb:	Slight:	Auditory /Type of Screening
Urinalysis:	Mod:	Right Pass / Fail
Gross Dental:	Marked:	Left Pass / Fail
Lead (Date/Result):	<input type="checkbox"/> Referral to:	

TB: In high-risk group? <input type="checkbox"/> yes <input type="checkbox"/> no		
TB & other Test Results: (Sickle Cell, etc.)		
Test	Date	Result

Disease Assessment

Yes	No		Date of Onset
<input type="checkbox"/>	<input type="checkbox"/>	Asthma <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Exercise Induced <input type="checkbox"/> Unclassified	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II	
<input type="checkbox"/>	<input type="checkbox"/>	Anaphylactic Reaction <input type="checkbox"/> Food <input type="checkbox"/> Insect <input type="checkbox"/> Latex <input type="checkbox"/> Other: Explain	
<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder Type:	
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox If yes, when?	
<input type="checkbox"/>	<input type="checkbox"/>	Mumps If yes, when?	
<input type="checkbox"/>	<input type="checkbox"/>	Other: Please Specify	

Immunization History

(Please provide month, day and year of immunization) – If your child has a religious or medical exemption from immunizations documentation is required

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DPT / Hib						
DTaP						
DT / Td						
OPV						
IPV						
MMR						
HiB						
Hep B						
Hep A						
Varicella						
TDap						
PCV						
HPV						
MCV						
Influenza						

Prescription Medication: Please complete with patient's current regimen for both scheduled and PRN medications including heparin flushes for central lines; please use additional paper if needed.

DRUG	ROUTE	DOSAGE	FREQUENCY	COMMENTS

Name _____

Date of Birth _____

Over the Counter Medication

The following medications will be provided by Green Chimneys Children's Health Services health center. These medications have been approved for use by the child's physician and requested by the parent.

Drug Name	Route	Dosage and schedule	Indications	Comments
Tylenol (or generic acetaminophen)	PO (chewable, elixir, or tabs)	Per label instructions by age/weight	Pain or fever (temp > 101 F)	Contact parent/guardian in the event of a fever
Ibuprofen	PO (chewable tabs, suspension or tabs)	Per label instructions by age/weight	Pain or fever (temp > 102 F)	Contact parent/guardian in the event of a fever
Benadryl (or generic)	PO (elixir, chewable tabs, or pills)	Per label instructions by age/weight	Allergic reactions (hives, insect bite)	Contact parent/guardian in the event of allergic reaction
Antibiotic ointment	Topical	Per label instructions by age/weight	Superficial cuts/abrasions	Check allergy history
Hydrocortisone Cream	Topical	Per label instructions by age/weight	Allergic reactions (contact dermatitis, insect bites)	
Calamine Lotion	Topical	Per label instructions by age/weight	Allergic reactions (hives, insect bites, poison ivy)	
Burn Gel	Topical	Per label instructions	Apply to minor burns	

Additional Orders: As deemed necessary by health care provider to be implemented by an RN:

Physicians Signature: _____

Date: _____

Physicians Stamp: (required):

Guardian Signature: _____

Date: _____

Please indicate if your child has one of these conditions:

Type 1 diabetes _____

Severe food allergy that requires epi pen or Benadryl _____

Type 2 diabetes _____

insect allergies that requires epi- pen or Benadryl _____

Asthma _____

If any of the above are checked please include your child's management plan with this form. If needed a management plan can be downloaded from our website:

Limitations on Activities: Swimming _____ Diving _____ Hiking _____ Athletics _____ Other: _____

Explain above: _____

HIPPA Privacy Statement: Permission to Release Confidential Health Information

I give _____ permission to release confidential health information to _____

Name of Medical Practice

regarding this person _____

Name of Camp

Name of Camper or staff member

Date: _____ Parents/Guardian Signature: _____

I certify that I have on this date examined the above named camper and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this camper to participate in physically strenuous activities.

Signature of Physician _____ Date of Examination _____

Please Print: Physician's Name _____ License# _____

Address _____ Phone# _____

Parents Signature: _____ Date: _____