

**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)

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

Explain any of the above: \_\_\_\_\_

**Medical History** (check yes or no)

	<b>Yes</b>	<b>No</b>	<b>Date</b>	<b>Details</b>
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 Covid-19\_\_\_?     Yes     No    If yes, when?    Date \_\_\_\_\_  
 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 and the submitted doctor's physical (**within 24 months of camp**) is up to date. There are no changes or updates to my child's health from submitted forms or ability to safely participate in camp activities. Any changes in my child's medical history will be submitted prior to camp.

I give my child permission to participate in all activities. In the event of accident or illness, I authorize the Green Chimneys 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:	<b>BMI:</b>	<b>Vision/Type of Screening</b>
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:	<b>Auditory /Type of Screening</b>
Urinalysis:	Mod:	Right Pass / Fail
Gross Dental:	Marked:	Left Pass / Fail
Lead (Date/Result):	<input type="checkbox"/> Referral to:	

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

## 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: \_\_\_\_\_