## Form A

## Health History & Examination Form

## for Children Attending Camp Shaver

Name Birthdate Sex Age

*Last First Initial*

Parent or Guardian

Home Address Phone

*Street & Number/City/State/Zip Area/Number*

Business Phone

*Street & Number/City/State/Zip Area/Number*

|  |  |  |
| --- | --- | --- |
| **Health History**  ***(Check/Give approximate dates.)***  Frequent Ear Infections  Heart Defect/Disease  Convulsions/Epilepsy  Diabetes  Bleeding/Clotting Disorders  Hypertension  Mononucleosis | **Diseases**  ***(Check/Give approximate dates.)***  Chicken Pox  Measles  German Measles  Mumps  Other: | **Allergies**  **(*Dates not needed.)***  Hay Fever  Ivy Poisoning, etc.  Insect Stings  Penicillin  Other Drugs  Asthma  Other *(Specify)* |

Operations or serious injuries *(dates)*

Chronic or recurring illness or medical conditions

Dietary restrictions/food allergies

Current medications (send with instructions) Name of dentist/orthodontist Phone Name of family physician Phone

Do you carry family medical/hospital insurance? ❏ No ❏ Yes Carrier Policy/Group #s / Carriers contact number/hotline

For female: Has this person menstruated?

If not, has she been told about it?

If so, is her menstrual history normal? Does applicant have epilepsy? ❏ Yes ❏ No

Does applicant have diabetes? ❏ Yes ❏ No

Special consideration

Does the applicant have any behavioral disorders? ❏ Yes ❏ No

If yes to any of the above please describe treatment recommendations.

## Form A

#### HEALTH CARE RECOMMENDATIONS BY LICENSED PHYSICIAN

Child’s name

*First/MI/Last*

I have examined the above camp applicant within the past 12 months. Date examined

In my opinion, the condition of the child named above is acceptable for his/her participation in an active camp program. *Physician’s initials*

Height

Weight

Blood Pressure

**Immunization History**

Please record the date (month/year) of basic immunizations and most recent booster doses.

|  |  |  |
| --- | --- | --- |
| **Vaccines** | **Month/Year of Basic Immunization** | **Month/Year of Last Booster** |
| Diphtheria  Pertussis (Whooping Cough) } DPT Tetanus  or |  |  |
| Tetanus  Diphtheria } TD  or |  |  |
| Tetanus |  |  |
| Oral Polio (Sabin) TOPV |  |  |
| Injectable Polio (Salk) |  |  |
| Measles (hard measles, red measles, Rubella) |  |  |
| Mumps |  |  |
| Rubella (German measles, 3-day measles) |  |  |
| Other |  |  |
| Tuberculin test given (most recent) |  |  |
| Haemophilus influenza b (HIB) |  |  |
| Hepatitis B |  |  |

The Administration of Camp Shaver and the Medical Advisors for Camp Shaver strongly discourage giving “breaks” or “vacations” from medications while at Camp Shaver, especially Behavioral Modification medications. Campers are often put into new and challenging situations and that can often introduce a new “stress” on a child, making behavior management more difficult.

Please list any recommended restrictions/concerns the camp administrator should know.

**Licensed Physician’s Signature**

Address **Phone**

***Street & Number/City/State/Zip*** *Area/Number*

Date of form completion By\*

*\*Initial if completed by nurse practitioner/physician’s assistant.*