



# 2010 Health Form for Campers and Staff

- Purpose and Use** This information is being collected to allow the camp to be aware of the health of its campers and staff, to record any examinations or treatments given to them while at camp and to have it available if needed by medical personnel.
- Disclosure** The information provided will be kept confidential and not disclosed, but some or all of it:
- may be consulted by the camp nurse when providing health care to the individual;
  - may be disclosed to those staff members who, in the opinion of the camp director, need to know the information for the health and safety of the individual or the other individuals attending the camp;
  - may be disclosed to ambulance attendants, physicians, hospitals or clinics providing medical attention to the individual.

## INDIVIDUAL AND FAMILY CONTACT INFORMATION

	<b>CAMPER or STAFF</b>	<b>FATHER</b> (or: _____ )	<b>MOTHER</b> (or: _____ )
<b>Last name</b>			
<b>First name</b>			
<b>Commonly called *</b>			
<b>Middle name</b>			
<b>Address</b>		IF DIFFERENT FROM THE CAMPER or STAFF	IF DIFFERENT FROM THE CAMPER or STAFF
<b>Work phone</b>	( _____ )	( _____ )	( _____ )
<b>Cell phone</b>	( _____ )	( _____ )	( _____ )
<b>Home phone</b>	( _____ )	( _____ ) IF DIFFERENT	( _____ ) IF DIFFERENT
<b>Fax</b>	( _____ )	( _____ )	( _____ )
<b>E-mail</b>			

\* if the individual is commonly known by a name other than their first name (e.g. "Kit"), specify it here.

**Emergency contact will be:** \*\* Mother \_\_\_\_ Father \_\_\_\_

If emergency contact is not the Mother or Father, \_\_\_\_\_: whose relationship and contact info is

<b>Name</b>		<b>Relationship to individual</b>	
<b>Address</b>		<b>Work phone</b>	( _____ )
		<b>Cell phone</b>	( _____ )
<b>E-mail</b>		<b>Home phone</b>	( _____ )

\*\*if the emergency contact will be at a different location (e.g. on holidays) while the individual will be at the camp, please attach a note with the necessary contact information.

## MEDICAL INFORMATION

Sex: Male\_\_\_\_ Female\_\_\_\_ Age: (as of Jun 30 of the camp year) \_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
YYYY MM DD

Health Card Number: \_\_\_\_\_ Version Code: \_\_\_\_\_

Family Physician  
 Name: \_\_\_\_\_ Phone: (\_\_\_\_\_)\_\_\_\_\_ Date of last examination \_\_\_\_/\_\_\_\_/\_\_\_\_  
YYYY MM DD

Other Physician (specialty \_\_\_\_\_)  
 Name: \_\_\_\_\_ Phone: (\_\_\_\_\_)\_\_\_\_\_ Date of last examination \_\_\_\_/\_\_\_\_/\_\_\_\_  
YYYY MM DD

**Physical Health History**

<b>General</b>	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Prescribed earplugs	<input type="radio"/>	<input type="radio"/>	Eyeglasses/contacts	<input type="radio"/>	<input type="radio"/>
Dental prosthesis	<input type="radio"/>	<input type="radio"/>	Girl menstruated?	<input type="radio"/>	<input type="radio"/>
Carries auto-injector	<input type="radio"/>	<input type="radio"/>	Carries a "Puffer"	<input type="radio"/>	<input type="radio"/>
Wears a Medic Alert Bracelet – please explain diagnosis & medical history:			<input type="radio"/>	<input type="radio"/>	

<b>Communicable Diseases</b>	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Chicken Pox	<input type="radio"/>	<input type="radio"/>	Mononucleosis	<input type="radio"/>	<input type="radio"/>
Hepatitis	<input type="radio"/>	<input type="radio"/>	Mumps	<input type="radio"/>	<input type="radio"/>
Measles, Red	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>
Measles, German	<input type="radio"/>	<input type="radio"/>	Whooping Cough	<input type="radio"/>	<input type="radio"/>
Other ( <i>specify</i> ) _____					

<b>Immunization</b>	<b>Year of last injection</b>
TDP (Tetanus, Diphtheria, Polio)	_____
MMR (Measles, Mumps, Rubella)	_____
Hepatitis B	_____
Hib (Haemophilus influenza type B)	_____
TB/BCG (Tuberculosis)	_____
Varicella Vaccine (Chicken Pox)	_____
Pneumococcal Conjugate	_____
Meningococcal Conjugate C	_____

<b>Other</b>	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Asthma	<input type="radio"/>	<input type="radio"/>	Homesickness	<input type="radio"/>	<input type="radio"/>
Bedwetting	<input type="radio"/>	<input type="radio"/>	Hypertension	<input type="radio"/>	<input type="radio"/>
Bleeding Disorder	<input type="radio"/>	<input type="radio"/>	Seizure Disorder	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Sinus Infections	<input type="radio"/>	<input type="radio"/>
Earaches	<input type="radio"/>	<input type="radio"/>	Skin Condition	<input type="radio"/>	<input type="radio"/>
Eating Disorder	<input type="radio"/>	<input type="radio"/>	Sleepwalking	<input type="radio"/>	<input type="radio"/>
Frequent Colds	<input type="radio"/>	<input type="radio"/>	Sore Throats	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	Stomach Aches	<input type="radio"/>	<input type="radio"/>
Hearing Disorder	<input type="radio"/>	<input type="radio"/>	Urinary Tract Infections	<input type="radio"/>	<input type="radio"/>
Heart Condition	<input type="radio"/>	<input type="radio"/>	Vision Disorder	<input type="radio"/>	<input type="radio"/>
Other ( <i>specify</i> ) _____					

The above are being treated as follows:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Physical restrictions** \_\_\_\_\_

**Recent operations, illness or injury** \_\_\_\_\_

**Dietary needs** \_\_\_\_\_

**Activities to be specifically encouraged** \_\_\_\_\_

**Treatments or special medications to be given while at camp** \_\_\_\_\_

**Personal Prescription, Over-the-Counter, or Alternative/Complementary Medication**  
*(brought in its original container with the individual's name, medication name, and dosage clearly visible and sufficient quantity)*

Name of Medication	Dosage	How/When Administered	Reason for taking

**Allergy History**

*(In all but the mildest reactions, we require detailed information about the individual's allergies to ensure adequate health care)*

<b>Allergies</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Foods	<input type="radio"/>	<input type="radio"/>	Medication	<input type="radio"/>	<input type="radio"/>
Insect Sting or Bite	<input type="radio"/>	<input type="radio"/>	Seasonal (hay fever)	<input type="radio"/>	<input type="radio"/>
Other (specify)	_____				

Where "yes", designate the allergy (s) and list the allergens (the substances which cause the reaction)

	<u><b>Allergy 1</b></u>	<u><b>Allergy 2</b></u>
Name: (e.g. bites)	_____	_____
Allergens:	_____	_____
	_____	_____
	_____	_____

<b>Nature of Reaction</b>	<u><b>Allergy 1</b></u>			<u><b>Allergy 2</b></u>		
	<u><b>Mild</b></u>	<u><b>Mod</b></u>	<u><b>Severe</b></u>	<u><b>Mild</b></u>	<u><b>Mod</b></u>	<u><b>Severe</b></u>
Hayfever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anaphylaxis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rash/Hives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<b>Re the most serious reaction</b>	<u><b>Allergy 1</b></u>	<u><b>Allergy 2</b></u>
Date of reaction	_____	_____
Symptoms	_____	_____
	_____	_____
	_____	_____

<b>Current Medical Treatment</b>	<u><b>Allergy 1</b></u>		<u><b>Allergy 2</b></u>	
	<u><b>Yes</b></u>	<u><b>No</b></u>	<u><b>Yes</b></u>	<u><b>No</b></u>
None	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-prescription medication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prescribed medication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Desensitization program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Under the care of the family doctor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Under the care of an allergy specialist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide details and date of last treatment:	_____			
	_____			

<b>Past Medical Treatment</b>	<u><b>Allergy 1</b></u>		<u><b>Allergy 2</b></u>	
	<u><b>Yes</b></u>	<u><b>No</b></u>	<u><b>Yes</b></u>	<u><b>No</b></u>
Injection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doctor visit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emergency room	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital admission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<b>Management Ability of the Individual</b>	<u><b>Allergy 1</b></u>		<u><b>Allergy 2</b></u>	
	<u><b>Yes</b></u>	<u><b>No</b></u>	<u><b>Yes</b></u>	<u><b>No</b></u>
Recognizes the reaction on their own	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Treats the reaction on their own (e.g. knows how to use auto-injector)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Requires assistance by adult	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Requires assistance by medical staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*Please review with the individual, both their medication and management, before they come to the camp.*

<b>Precautions and Medication Taken</b>	<b>Allergy 1</b>	<b>Allergy 2</b>
Regular medications (name/frequency)		
Medications as required (name/frequency)		
Emergency measures (type/instructions)		

