

Health History and Examination Form for Pleasant Hill Outdoor Center

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.

Name _____ Birth Date _____ Sex _____ Age _____
Last First MI

Parent or Guardian (or Spouse) _____

Home Address _____ Phone _____
Street & Number City State Zip Area & Number

Business _____ Phone _____
Street & Number City State Zip Area & Number

Second Parent/ Guardian/ Emergency Contact _____

Home Address _____ Phone _____
Street & Number City State Zip Area & Number

Business _____ Phone _____
Street & Number City State Zip Area & Number

If not available in an emergency, notify

Name _____

Address _____ Phone _____
Street & Number City State Zip Area & Number

Operations or serious injuries (dates) _____

Dietary restrictions _____

Current medications (accepted in prescription bottle only) _____

Name of dentist/ orthodontist _____ Phone _____

Name of family physician _____ Phone _____

Do you carry family medical insurance? Yes No

If so, indicate: Carrier _____ Policy or Group # _____

Carrier Address _____

Suggestions on health related information for camp personnel _____

For Female

Has this person menstruated? _____ if not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special Consideration _____

<p>Health History <i>(Check, Give approximate dates.)</i></p> <p>_____ Frequent Ear Infections</p> <p>_____ Heart Defect/ Disease</p> <p>_____ Convulsions</p> <p>_____ Diabetes</p> <p>_____ Bleeding/ Clotting</p> <p>_____ Hypertension</p> <p>_____ Mononucleosis</p> <p>Diseases</p> <p>_____ Chicken Pox</p> <p>_____ Measles</p> <p>_____ German Measles</p> <p>_____ Mumps</p> <p>Allergies <i>(Dates not needed)</i></p> <p>_____ Hay Fever</p> <p>_____ Ivy Poisoning etc.</p> <p>_____ Insect Stings</p> <p>_____ Penicillin</p> <p>_____ Other Drugs</p> <p>_____ Asthma</p> <p>_____ Other <i>(Specify)</i></p>
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Important—This section must be completed for attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/ or my child. I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed records may be photocopied and used by a physician for trips out of camp.

Signature of parent or guardian or adult camper/ staffer _____

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor or adult camper/ staffer _____ Date _____

Name _____ Date Examined _____ Cabin _____ Year _____

Immunization History

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

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (<i>Whooping Cough</i>) Tetanus or		
Tetanus Diphtheria or		
Tetanus		
Oral Polio (sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, rubeoia)		
Other		
Tuberculin test given _____ (<i>most recent</i>)		
Haemophilus influenza b (HIB)		
Hepatitis B		
Varicella		

I choose NOT to have my camper examined by a licensed physician prior to attending camp and I hold harmless Pleasant Hill Outdoor Center and employees/ volunteers for any information not provided below by a licensed physician.

-OR-

Health Care Recommendations by Licensed Physician (copy of recent physical, last 2 yr, acceptable in lieu)

I have examined the above camp applicant within the past two years. Date Examined _____

In my opinion, the above's condition DOES or DOES NOT preclude his/ her participation in an active camp program.

Height _____ Weight _____ Blood Pressure _____

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

Current treatment (include current medications) _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Does applicant have epilepsy? Yes No

Does applicant have diabetes? Yes No

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp _____

Any medication to be administered at camp (specific dosages) _____

Any medically prescribed dietary restrictions _____

Any Allergies (food, drugs, plants, insects, etc.) _____

Activities to be encouraged or limited _____

Additional Health Information _____

Licensed Physician's Signature _____

Address _____ Phone _____
Street & Number City State Zip Area & Number

Date of Form Completion _____ *BY _____

*Initial if completed by nurse or physician's assistant