Health History and Examination Form, 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*

Buisness ____ Phone ______________________
Street & Number *City* *State* *Zip* *Area & Number*

Second Parent/ Guardian/ Emergency Contact ____

Home Address ____ Phone ______________________
Street & Number *City* *State* *Zip* *Area & Number*

Buisness ____ 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*

Health History
(Check, Give approximate dates.)
_________Frequent Ear Infections
_________Heart Defect/ Disease
_________Convulsions
_________Diabetes
_________Bleeding/ Clotting
_________Hypertension
_________Mononucleosis

Diseases
_________Chicken Pox
_________Measles
_________German Measles
_________Mumps

Allergies *(Dates not needed)*
_________Hay Fever
_________Ivy Poisoning etc.
_________Insect Stings
_________Penicillin
_________Other Drugs
_________Asthma
_________Other *(Specify)*
____
____

Operations or serious injuries (dates) ______________________________________
____

Dietary restrictions ____

Current medications (send with instructions) _________________________________
____

Name of detist/ 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 ________
____

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 *(Whooping Cough)* Tetanus or		
Tetanus Diphtheria or		
Tetanus		
Oral Polio (sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, rubeoia)		
Other		
Tuberculin test given _______ *(most recent)*		
Haemophilus influenza b (HIB)		
Hepatitis B		

❑ **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*