Camp Millhouse **2010***Health Form

Camper Name____ Sex __M __F
Age at time of attendance_______________ Date of Birth____________ S.S. #___________________________
Address____
City ____ State_________ Zip code________________________
Day phone_______________ Evening phone____________________ Cell Phone ____________________

EMERGENCY CONTACT (TWO CONTACTS NOT OF THE SAME HOUSE HOLD)
Name____ Relationship__________________________
City____ State__________ Zip Code________________________
Day Phone__________________ Evening Phone_________________ Cell Phone ____________________

Name____ Relationship _____________
City____ State_____________ Zip Code___________________
Day Phone_______________________ Evening Phone_______________ Cell Phone __________________

INSURANCE PLEASE ENCLOSE A COPY OF INSURANCE CARD (S)
Company Name____
Policy Number____Phone_______________________
Medicaid/Other Numbers____
Dentist/Orthodontist____ Phone______________________

PERMISSION TO TREAT

I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; 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/my child/client. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. I hereby give permission for the named above to engage in all prescribed camp activities, including the **Low Ropes Course,** appropriate for age and ability, except as noted. This completed form may be photocopied for trips out of camp

Guardian Signature _____________________________ Witness ___________________________ Date ___________

Health History please list dates where applicable

Chronic Conditions

- ❑ Heart Conditions
- ❑ Seizures (please list typical seizure activity and length) __________________ ________________
- ❑ Asthma
- ❑ Bone/Joint problems
- ❑ Head Injury
- ❑ Hepatitis A B or C
- ❑ HIV Positive
- ❑ Dietary Restrictions
- ❑ Circulatory condition
- ❑ Diabetes – ***Please include insulin regimen on medication sheet***
- ❑ ________________
- ❑ ________________

Allergies

- ❑ Latex
- ❑ Medication (please list)
- ❑ Insect bites
- ❑ Grass molds ect.
- ❑ Foods (please list)
- ❑ Other

____
____
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MISC. Information

- ❑ Straight Cath. (frequency) __________________
- ❑ Foley Cath
- ❑ Ostomy _____________________________
- ❑ G-Tube (please provide rate and times of feedings. You will need to provide your own pumps, supplies and food __________________ ______________________________
- ❑ C-Pap – must supply equipment and supplies
- ❑ Oxygen
- ❑ Ear Infections
- ❑ Bleeding problems
- ❑ Fainting spells
- ❑ Hernia
- ❑ Chicken Pox
- ❑ Mumps
- ❑ Mono
- ❑ Swallowing problems
- ❑ TB (date) ___________________________
- ❑ Foot Problems _______________________
- ❑ Skin Conditions: Dry Eczema Bruising Scrapes Open wounds Cellulites

- ❑ VNS
- ❑ Pacemaker
- ❑ Baclofen pump
- ❑ Shunt of any kind

Please list any surgeries, procedures or hospitalizations in the past 3 years:

Please Turn Over

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Type	**Date(s)**	**Type**	**Date(s)**
Tetanus – **MUST HAVE DATE**		**MMR**	
Polio		**Hep A**	
TB		**Hep B**	

Please fill this out Immunizations completely filled out. If not the form will be returned to you.
TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER **(MD. N.P, P.A, D.O.)**

Camper's Name ____ Date of Exam ______________
History of reaction to food, serum, drugs or medications? ____ Yes ____ No
Explain: ____
Sex __________ Age _________ Height _______ Weight _______ B/P ________ Pulse ______ Resp _____
Visual impairment Yes _____ No ______
Hearing: Right normal Yes _____ No _____ Left normal Yes _____ No _____
Impairment: ____

System	Satisfactory	Unsatisfactory	Describe Abnormalities
Skin, Lymphatic			
Eyes			
Ears			
Mouth			
Nose, throat			
Neck, thyroid			
Chest, breasts, lungs			
Heart rate/rhythm			
Heart murmur (describe)			
Abdomen, liver, kidneys, spleen			
Hernia			
Genitalia			
Pelvic			
Rectal			
Extremities (back, spine)			
Joints			
Neurological			
Psychological			

Current medications names and dosage____
____
The following abnormalities should be noted: ____
____
The camper ___ does ___does not have a history of emotional, psychological or psychiatric disturbance.____
Applicant may participate in camp activities: ___ with restriction ___ with out restriction
Camper should not participate in sports. Reason for limiting activity: ____________________________

Health Care Provider (please print)
Name: ____
Address: ____
Signature: ____________________________________ Phone: ________________________

Signature of Physicians ____ Date: _______________________

Camp Millhouse Office Use Only

Date received:

Date returned:

Date received:

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, P/procedures