

**Camp Sertoma Health
History and Examination Form
For Youth attending Camp Sertoma**

Camp Sertoma Dates:
____ July 10-15, 2011
____ July 17-22, 2011

Mail completed form to:
Camp Sertoma
1620 Mary Fawcett Mem. Dr
East Gull Lake, MN 56401

The information on this form is not part of the camper acceptance process, but is gathered to assist in identifying appropriate care. Health history must be filled out by a parent/guardian of minors. Update is required annually.

Health exam (last page) must be completed by an approved licensed medical personnel no more than 24 months prior to attending Camp Sertoma.

Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address _____
Street address City State Zip

Social Security number of participant _____ Gender _____

Custodial Parent/Guardian _____ VP/Phone/Pager _____

Home address _____
(if different from above) Street address City State Zip

Business address _____ Phone/Pager/VP _____
Street address City State Zip

Second parent or guardian emergency contact _____

Address _____ Phone/Pager _____
Street address City State Zip

Business address _____ Phone/Pager _____
Street address City State Zip

If not available in an emergency, notify:

Name _____ Phone/Pager _____

Address _____ Relationship _____
Street address City State Zip

Insurance Information

Is participant covered by family medical/ hospital insurance? _____ Yes _____ No

If yes, indicate carrier or plan number _____ Group # _____

*** Photocopy of front and back of health card must be attached to this form***

Parent/Guardian Authorization: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to Camp Sertoma to provide routine health care, administer prescription medications, and seek emergency treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to Camp Sertoma to arrange necessary related transportation for me/my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Sertoma to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper or staff member _____

Printed Name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities

Signature of minor or adult camper or staff _____ Date _____

**If for religious reasons, you cannot sign this, contact Camp Sertoma for a legal waiver that must be signed for attendance.*

GENERAL QUESTIONS (Explain “yes” answers below.)

Has/does the participant:

- | | | |
|---|-----------|----------|
| 1. Had any recent injury, illness or infectious disease? | _____ Yes | _____ No |
| 2. Have a chronic or recurring illness/condition? | _____ Yes | _____ No |
| 3. Allergy to latex? | _____ Yes | _____ No |
| 4. Ever been hospitalized? | _____ Yes | _____ No |
| 5. Ever had surgery? | _____ Yes | _____ No |
| 6. Have frequent headaches? | _____ Yes | _____ No |
| 7. Has any known allergies? | _____ Yes | _____ No |
| 8. Ever had a head injury? | _____ Yes | _____ No |
| 9. Ever been knocked unconscious? | _____ Yes | _____ No |
| 10. Wear glasses, contacts or protective eyewear? | _____ Yes | _____ No |
| 11. Wear hearing aids or cochlear implant? | _____ Yes | _____ No |
| 12. Ever had frequent ear infections? | _____ Yes | _____ No |
| 13. Ever passed out during or after exercise? | _____ Yes | _____ No |
| 14. Ever been dizzy during or after exercise? | _____ Yes | _____ No |
| 15. Ever had seizures? | _____ Yes | _____ No |
| 16. Ever had chest pain during or after exercise? | _____ Yes | _____ No |
| 17. Ever had high blood pressure? | _____ Yes | _____ No |
| 18. Ever been diagnosed with a heart murmur? | _____ Yes | _____ No |
| 19. Ever had back problems? | _____ Yes | _____ No |
| 20. Ever had problems with joints (e.g. knees, ankles)? | _____ Yes | _____ No |
| 21. Have an orthodontic appliance being brought to Camp? | _____ Yes | _____ No |
| 22. Have any skin problems (e.g. itching, rash, acne)? | _____ Yes | _____ No |
| 23. Have diabetes? | _____ Yes | _____ No |
| 24. Have asthma? | _____ Yes | _____ No |
| 25. Have mononucleosis in the past 12 months? | _____ Yes | _____ No |
| 26. Has problems with diarrhea/constipation? | _____ Yes | _____ No |
| 27. Have problems with sleepwalking? | _____ Yes | _____ No |
| 28. If female, have an abnormal menstrual history? | _____ Yes | _____ No |
| 29. Have a history of bed-wetting? | _____ Yes | _____ No |
| 30. Ever had an eating disorder? | _____ Yes | _____ No |
| 31. Ever had emotional difficulties for which professional help was sought? | _____ Yes | _____ No |
| 32. Have any special behavioral needs? | _____ Yes | _____ No |
| 33. Have any special physical needs? | _____ Yes | _____ No |

Please explain any “yes” answers, noting the number of the questions:

Use this space to provide any additional information about the participant’s behavior and physical, emotional, or mental health about which the Camp should be aware. (Use additional paper if needed)

Health History

The following information must be filled in by the parent/guardian, adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to Camp Sertoma health personnel upon participant’s arrival in Camp. Provide complete information so that Camp can be aware of your needs.

Allergies List all known

Describe reaction and management of the reaction

Medication allergies (list)

Food allergies (list)

Other allergies (list) include insect stings, hay fever, asthma, animal dander, etc.

Medications being taken

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. **Keep it in the original packaging/bottle that identifies the prescribing physician** (if a prescription drug) the name of the medication, the dosage, and frequency of administration.

____ This person takes NO medications on a routine basis

____ This person takes medications as follows:

Med# 1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med#2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med#3 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med#4 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med#5 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med#6 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Attach additional pages for more medication.

Identify any medications taken during the school year that participant does/may not take during the summer

Name of family physician _____ Phone _____
 Address _____ Phone _____
 Name of family dentist/orthodontist _____
 Address _____

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

_____ Does not eat red meat _____ Does not eat pork _____ Does not eat eggs
 _____ Does not eat dairy products _____ Does not eat seafood _____ Does not eat poultry
 _____ Other (describe)

Explain any restrictions to activity (e.g. what cannot not be done, what adaptations or limitations necessary)

Which of the following Has the participant had?	Please give all dates of immunizations for: Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
_____ Hepatitis A	DTP	_____	_____	_____	_____	_____	_____
_____ Chicken Pox	TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
_____ Measles	Tetanus	_____	_____	_____	_____	_____	_____
_____ Mumps	Polio	_____	_____	_____	_____	_____	_____
	MMR	_____	_____				
	or Measles	_____	_____				
	or Mumps	_____	_____				
	or Rubella	_____	_____				
TB Mantoux Test	Haemophilus influenza	_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B	_____	_____	_____	_____	_____	_____
Result:	Varcella (chicken pox)	_____	_____				
Positive _____ Negative _____							

You may have a physician fill out and sign the bottom portion or have the physician's office fax the following information to Camp Sertoma (218) 828-2618 on a separate form. **Health Exam must be no more than 24 months prior attending Camp.**
 *Date of Health Examination
 *Signature and date from physician
 *Current or on-going treatments or medications
 *Any physical conditions requiring restrictions while at Camp Sertoma, and list restrictions.

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____
 BP _____ Weight _____ Height _____
 In my opinion, the above applicant ___ is ___ is not able to participate in an active camp program.
 The applicant is under the care of a physician for the following conditions

Recommendations Restrictions at Camp

Please explain _____

Signature of Licensed Medical Personnel _____
 Printed _____ Title _____
 Address _____
 Phone _____ Date _____