

Health History

The following information must be filled in by the applicant or parent/guardian. The purpose of this information is to provide the camp health care personnel the background to deliver appropriate care. Keep a copy of this completed form for your records. Any changes to this form should be given to the Camp Director upon the applicant's arrival at Camp Victory Lake. Provide complete information so that the 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

Medication Being Taken

Please list ALL medications (including over the counter or non-prescription drugs) taken routinely. Bring enough medication to last you for the entire stay 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 the frequency of administration.

This person takes no medication on a regular basis.

This person takes the medications as follows: **B** - Breakfast; **L** - Lunch; **D** - Dinner; **S** - Evening snack

Med. #1 _____ Dosage _____ Specific mealtime each day _____

Reason for taking _____

Med. #2 _____ Dosage _____ Specific mealtime each day _____

Reason for taking _____

Med. #3 _____ Dosage _____ Specific mealtime each day _____

Reason for taking _____

Attach additional pages for more medications.

Identify any medication taken during the pass year that may not take during the summer. _____

Restrictions

(Dietary (list) _____

Explain any restriction to activities (e.g. what cannot be done, what adaptations or limitations are necessary)

General Questions (Explain "yes" answers below)

Has/does the applicant:	Yes	No	Yes	No
1. Had any recent injury, illness or infectious disease? .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>		
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>		
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>		
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>		
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>		
7. Ever been knocked unconscious	<input type="checkbox"/>	<input type="checkbox"/>		
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>		
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>		
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
11. Ever been dizzy during or after exercises?	<input type="checkbox"/>	<input type="checkbox"/>		
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>		
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>		
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>		
16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>		
			17. Ever had problems with joints (e.g. knees, ankle)?	<input type="checkbox"/>
			18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>
			19. Have any skin problems (e.g. itching rash, acne?	<input type="checkbox"/>
			20. Have diabetes?	<input type="checkbox"/>
			21. Have asthma?	<input type="checkbox"/>
			22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>
			23. Had problems with diarrhea/constipation?	<input type="checkbox"/>
			24. Have problems with sleepwalking?	<input type="checkbox"/>
			25. If female, have an abnormal menstrual history?	<input type="checkbox"/>
			26. Have a history of bed-wetting?	<input type="checkbox"/>
			27. Ever had an eating disorder?	<input type="checkbox"/>
			28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>

Please explain any "yes" answers, noting the number of the questions.

Which of the following has the applicant had?	Please give all dates of immunization for:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Measles	DTP	_____	_____	_____	_____	_____
<input type="checkbox"/> Chicken Pox	TD (tetanus/diphtheria)	_____	_____	_____	_____	_____
<input type="checkbox"/> German measles	Tetanus	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Polio	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	MMR	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Measles	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Mumps	_____	_____	_____	_____	_____
	or Rubella	_____	_____	_____	_____	_____
TB Mantoux Test	Haemophiles Influenza B	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B	_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (chicken pox)	_____	_____	_____	_____	_____

Use this space to provide any additional information about the participants' behavior and physical, emotional, or mental health about which the camp should be aware.

Name of family physician _____ Phone _____
 Address _____

Name of family dentist/orthodontist _____ Phone _____
 Address _____

Health Care Recommendation by Licensed Medical Personnel

I have examined this camper. Date of last examination _____

BP _____ Weight _____ Height _____

In my opinion, the 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:

Current treatment at the time of this report includes:

Recommendations and Restrictions at Camp

(Treatment to be continued at camp)

Medications to be administered at camp (name, dosage, frequency) _____

Any medically-prescribed meal plan or dietary restrictions _____

Known allergies _____

Description of any limitation or restriction on camp activities _____

Additional information for health care staff at Camp Victory Lake _____

Signature of Licensed Medical Personnel

Printed _____ Title _____

Address _____

FOR CAMP VICTORY LAKE USE ONLY.

SCREENING RECORD

Date screened _____ Time _____ **am**

Meds. received _____ **pm**

Updates/ additions to health history noted _____

Current health needs identified _____

Observation notes _____

Screened by _____

