Camper Medical Form - Summer 2008

The information on this form is not part of the camper acceptance process but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians. Page 4 to be completed by Physician.

Gender: Male Female
Name____
Last First Middle
Birth date__________ Age at camp_______

Home address____
Street address City State Zip

Custodial parent/guardian________________________________Cell Phone___________________

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

Business address____ Bus Phone_______________
Street address City State Zip

Second parent / guardian / emergency contact________________________ Cell Phone_______________
(please circle one)

Address____ Home Phone______________
Street address City State Zip

Business address+____ Bus Phone______________
Street address City State Zip

If above not available in an emergency, notify:
Name____ Cell Phone_________________

Relationship____ Day Phone_________________

Address____
Street address City State Zip

Insurance Information
Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name___________________________ Group #______________________
Tele #_______________

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.

Mail this form to the address below by _6/1/08_

RIVERDALE TENNIS CAMP
C/O RIVERDALE TENNIS CLUB
699 WEST 239 STREET APT 6S
RIVERDALE, NY 10463

Use this space to provide any additional information about the participant's behavior, physical, emotional, or mental health about which the camp should be aware. Please be assured that all information provided on this form will be kept confidential.

ALL MEDICATIONS BEING TAKEN
Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely.

MEDICATIONS ADMINISTERED DURING CAMP

· Must be accompanied by a doctor's written order
• Keep in original packaging/bottle that identifies the prescribing physician (if prescription drug), the name of the medication, dosage, and frequency of administration
• Please provide sufficient medications for entire camp session
• All medications will be administered/stored by camp nurse

RESTRICTIONS
The following restrictions apply to this individual.
Dietary

Does not drink milk   Does not eat red meat   Does not eat fish
Does not eat ice cream   Does not eat poultry   Does not eat eggs
Does not eat other dairy products
Other
(describe)____________________

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

____

____

____

____

General Questions (Explain "yes" answers below)
Has/does the participant: **Yes No Yes No**

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____
Attach additional pages for more medications.

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

Has/does the participant: **Yes No**

1. Had a recent injury, illness or infectious disease?
2. Have a chronic or recurring illness/condition?
3. Ever been hospitalized?
4. Ever had surgery?
5. Have frequent headaches?
6. Ever had a head injury?
7. Ever been knocked unconscious?
8. Wear glasses, contacts, or protective eyewear?
9. Ever had frequent ear infections?
10. Ever passed out during or after exercise?
11. Ever been dizzy during or after exercise?
12. Ever had seizures?
13. Ever had chest pain during or after exercise?
14. Ever had high blood pressure?
15. Been diagnosed with a heart murmur?
16. Ever had back problems?
17. Ever had problems with joints (e.g. knees, ankles)?
18. Have an orthodontic appliance being brought to camp?
19. Have any skin problems (e.g. itching, rash, acne, eczema)?
20. Have diabetes?
21. Have asthma?

22. Had mononucleosis in the past 12 months?
23. Had problems with diarrhea/constipation?
24. If female, have an abnormal menstrual history?
25. Ever had an eating disorder?
26. Ever had emotional difficulties for which professional help was sought?

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

Date of last medical examination: ____
Which of the following Please give all dates of immunization for (or attach immunization has the participant had? form from M.D.)

Measles Vaccine: Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr
Chicken pox DTP _____ _____ _____ _____ _____ _____
German measles TD(tetanus/diphtheria) _____ _____ _____ _____ _____ _____
Mumps Tetanus _____ _____ _____ _____ _____ _____
Hepatitis A Polio _____ _____ _____ _____ _____
Hepatitis B MMR _____ _____
Hepatitis C or Measles _____ _____
or Mumps _____ _____
TB Mantoux Test or Rubella _____ _____
Date of last test__________________ Haemophilus influenza B _____ _____ _____ _____
Result: Positive Negative Hepatitis _____ _____ _____
Varicella (chicken pox) _____ _____
Name of family physician____
Phone__________________________________
Address____

Name of family dentist/orthodontist____
Phone__________________________________
Address____

Parent/Guardian Authorization

This health history is correct and complete as far as I know. In the event I cannot be reached in an emergency, I The person herein described has permission to engage in hereby give permission to the physician selected by all camp activities except as noted. the camp to secure and administer treatment, including hospitalization, for the person named above I hereby give permission to the camp to provide routine health with the understanding that the family will be notified care, administer over the counter and/or prescribed medications as soon as possible. This completed form may be with doctor’s orders only, and seek emergency medical treatment photocopied for trips out of camp. including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or I also understand and agree to abide by any insurance purposes. I give permission to the camp to restrictions placed on my child’s participation in camp arrange necessary related transportation for my child. activities.

Signature of parent/guardian ____
Printed name____ Date____________________________

Health Care Recommendations by Licensed Medical Personnel

I examined the individual on ______________. (Exam must be within past 18 months of camp attendance)

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 and Restrictions at Camp
Treatment to be continued at camp

____
____

Medications, including over-the-counter, to be administered at camp (name, dosage, frequency); **MUST BE ACCOMPANIED BY A DOCTOR'S WRITTEN ORDER.**

____
____

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 the camp

____
____

For camp use only

Signature of Licensed Medical Personnel____

Printed__________________________________ Title____

Address____

Phone____ Date______________________

Screening Record
Date screened____

Meds received____
____

Updates/additions to health history noted Yes No None required
Current health needs identified____
____
Observational notes____
____
Screened by_____________________________