

CAMP WOODMONT - HEALTH HISTORY AND MEDICAL INFORMATION FORM

This form has two sections: Pages 1-3 for parents/staff/campers and Page 4 for licensed medical personnel. Both sections should be completed, signed and returned with a PHOTOCOPY of front and back of camper's/ staff member's insurance card as soon as possible (at least one month prior to camp attendance).

Camp policy requires a new form each year of camp attendance

BEFORE MAY 15, MAIL TO:

Camp Woodmont
551 Chatata Valley Rd.
Cleveland, TN 37323

AFTER MAY 15, MAIL TO:

Camp Woodmont
381 Moonlight Dr.
Cloudland, GA 30731

CALL 423-472-6070 or 706-398-0833 if you have a question about this form.

CAMP SESSION (LIST DATES):

Sunday _____ to Friday _____
CHECK-IN DATE PICK-UP DATE

Camper's Name _____ Parent's Names _____
LAST FIRST MIDDLE List Mother, Father and step-parent (if applicable).

Camper's Date of Birth _____ Age at camp _____ Social Security # _____ Sex: Male Female

Home Address _____
STREET ADDRESS CITY STATE ZIP

Home Phone _____ Cell Phone _____

Business Address and Work Phone Mother WORK PHONE _____

STREET ADDRESS CITY STATE ZIP

Business Address and Work Phone Father: WORK PHONE _____

STREET ADDRESS CITY STATE ZIP

Emergency contact: Name _____ Relationship _____

Address _____ Phone _____ Work/Alternate Phone _____
STREET ADDRESS CITY STATE ZIP

Parent's acknowledgment and authorization to secure medical treatment: By completing and signing this form, I acknowledge and affirm that I am the actual custodial parent and/or legal guardian of the above named camper and that all information given is accurate and complete. I also give permission for my child to participate in all camp activities except as noted on this form. I also give permission for the camp to provide routine health care, administer prescribed and over-the-counter medication, and to secure emergency medical treatment including x-rays, lab tests, emergency transportation and any other treatment recommended by camp medical staff and/or recommended by licensed medical professionals selected by the camp. I authorize the release of any records necessary for treatment and/or insurance billing purposes. I acknowledge that the above listed camper is covered by our own family's health insurance and/or that I am financially responsible for medical treatment if needed. In case I cannot be reached in an emergency, I give permission to the physician and/or hospital selected by the camp to provide any and all medical treatment deemed necessary for the camper listed above including hospitalization. This form may be photocopied for camp field trips and/or when taking a camper to the doctor.

SIGNATURE OF PARENT/LEGAL GUARDIAN _____
Or Adult Staff member

PRINTED NAME _____ DATE _____

Camper/Staff acknowledgement and agreement: I understand and agree to abide by any restrictions placed on my participation in camp activities.

Camper/Staff Signature _____ DATE _____

HEALTH NSURANCE NAME OF INSURANCE COMPANY./PLAN _____

POLICY # _____ GROUP # _____

ATTACH a photocopy of front and back of health insurance card and return with this form.

Camper/Participant's Name (please list name on every page) _____

CAMPER AND STAFF MEDICAL HISTORY - All information is confidential and is used by camp medical staff to provide and maintain proper health care and safety at camp. Please provide complete and accurate information.

ALLERGIES- List all allergies and describe reaction and management of reaction.

Medication allergies (drugs, medicine) _____

Food Allergies _____

Other allergies (insect stings, asthma, plants etc.) _____

MEDICATIONS CAMPER OR STAFF MEMBER TAKES: List all medications including over-the-counter and non-prescription. Bring in the original container with physicians name (for prescribed meds), name of medication, dosage and frequency. Bring appropriate amount/quantity for the length of camp stay.

CHECK HERE if Camper/Staff member does NOT take any medication on a routine basis.

MEDICATION TAKEN ROUTINELY (list prescription and non-prescription):

1: Name of Medication _____ Dosage _____ Frequency (time taken) _____

Reason for taking _____

2. Name of medication _____ Dosage _____ Frequency _____

Reason for taking _____

3. Name of medication _____ Dosage _____ Frequency _____

Reason for taking _____

Attach additional page for more medications.

Are there any medications taken during school year that are **not** taken during summer? Yes No

If YES, list name of medication and reason taken during school year: _____

ACTIVITY AND DIETARY RESTRICTIONS:

Check here if participant has NO dietary restrictions.

List dietary restrictions: _____

Check here if participant has NO activity restrictions.

List **and explain** activity restrictions _____

Camper/Participant's Name (please list name on every page) _____

General Health History: Has the participant ever had or does the participant currently have:

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Have a chronic or recurring illness/condition?..... | <input type="checkbox"/> | <input type="checkbox"/> | 15. Ever had frequent ear infections?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Had a recent injury, illness or contagious disease?.. | <input type="checkbox"/> | <input type="checkbox"/> | 16. Have an orthodontic or prosthetic appliance at camp?.. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized?..... | <input type="checkbox"/> | <input type="checkbox"/> | 17. Ever had problems with joints?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery?..... | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have any skin problems?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches?..... | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have diabetes?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury or been knocked unconscious?..... | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have asthma?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever had seizures?..... | <input type="checkbox"/> | <input type="checkbox"/> | 21. Had problems with diarrhea/constipation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Ever had back problems?..... | <input type="checkbox"/> | <input type="checkbox"/> | 22. Have problems with sleepwalking?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever been dizzy during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> | 23. Have a history of bed-wetting?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> | 24. Ever had emotional problems or anxiety?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever had chest pain during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> | 25. Ever had an eating disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever been diagnosed with a heart murmur?..... | <input type="checkbox"/> | <input type="checkbox"/> | 26. If female, had menstrual problems?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had high blood pressure?..... | <input type="checkbox"/> | <input type="checkbox"/> | 27. Have any other illness or disease not covered in these questions?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Wear glasses, contacts or protective eye wear?.... | <input type="checkbox"/> | <input type="checkbox"/> | | | |

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

CHILDHOOD ILLNESSES: Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test
Date of last test _____
Result _____

IMMUNIZATION HISTORY: Give all dates for the following:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
DTP		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
Measles		_____	_____	_____	_____	_____	_____
Mumps		_____	_____	_____	_____	_____	_____
Rubella		_____	_____	_____	_____	_____	_____
Haemophilus Influenza B		_____	_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Is there any other information concerning the participant's physical, emotional, mental health or behavior that we need to be aware of (please describe below, all information is confidential and is used to help us better serve the needs of your camper/staff member): _____

Camper/Participant's Name (please list name on every page) _____

Health examination and recommendations by Licensed Medical Professional - This section to be completed by a physician or licensed health care professional.

DATE OF LAST EXAM: _____ Height _____ Weight _____ BP _____

In my opinion, this participant is, or is not, able to participate in an active camp program.

This participant is under medical care for the following conditions:

Recommendations and Restrictions at camp (describe and explain):

Treatment to be continued at camp: _____

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

Allergies: _____

Description of any limitations or restrictions on camp activities: _____

Additional information for camp health care staff: _____

Signature of Licensed Medical Personnel _____

Printed name _____ **Title** _____

Address _____ **Date** _____ **Phone** _____

Camp screening record (for camp use only):

Date Screened _____ Time _____

Meds Received (list each) _____

Updates to health history Yes No None needed

Current health needs identified _____

Notes _____ Screened by _____