SUDBURY PARK & RECREATION

CAMP HEALTH HISTORY AND EXAMINATION FORM

Health history must be filled out by parents/guardians of minors. Please also submit a copy of the participant's most recent physical exam and immunization record, dated within the past 18 months (update required annually). **These forms must be submitted at least four business days prior to the start of a camp program.** If forms are not received by the deadline, your child will not be able to participate.

The following information must be filled in by the parent/guardian. The intent of this information is to provide our health care personnel background information to provide appropriate care. Keep a copy of the completed form for your records.
If you need to make changes or updates to this form at any time, please contact us.

Name _____ Birth Date _____ Age _____
Last First Middle

Home address_____
Street Address City State Zip

Gender: ☐ Male ☐ Female

Custodial parent/guardian_____ Phone_____

Home address_____
(If different from above) *Street Address City State Zip*

Business Address_____ Phone_____
Street Address City State Zip

Second parent/guardian_____ Phone_____

Home address_____
(If different from above) *Street Address City State Zip*

Business Address_____ Phone_____
Street Address City State Zip

Emergency contact _____

Relationship_____ 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 #_____

Family Physician_____ Phone_____

Address_____
Street Address City State Zip

Family Dentist/Orthodontist_____ Phone_____

Address_____
Street Address City State Zip

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ALLERGIES List all known and 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. Our nurse will handle all medications during each session. Please provide prescription from doctor if taken at camp, as well as a Medication Authorization Form. Please keep medications 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 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:

_____

RESTRICTIONS

The following restrictions apply to this individual.

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

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General Questions Has/does the participant? (Check if "Yes")

1. Had any 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 or concussion? ☐
7. Ever been knocked unconscious? ☐
8. Wear glasses, contacts or protective eye gear? ☐
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. Ever 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 brought to camp? ☐
19. Have any skin problems (e.g., itching rash, acne)? ☐
20. Have diabetes? ☐
21. Have asthma? ☐
22. Had mononucleosis in the past 12 months? ☐
23. Had problems with diarrhea/ constipation? ☐
24. Have problems with sleepwalking? ☐
25. If female, have an abnormal menstrual history? ☐
26. Have a history of bed-wetting? ☐
27. Ever had an eating disorder? ☐
28. Had emotional difficulties for which professional help was sought? ☐

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 of.

_____

_____

_____

Please describe your child's swim ability and/or level of last completed Red Cross swim lesson:

_____

_____

_____

Parent/Guardian Authorizations:

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 provide routine health care by the physician selected by the camp, to secure and administer treatment, including prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for hospitalization, for the person named above. This completed form may be photo- copied for our trips.

In the event I cannot be reached in an emergency, I hereby give my permission for treatment, emergency transportation to health care facility, referral, billing, or insurance purposes.

I give permission to arrange necessary related emergency transportation for me/my child.

Signature of parent/guardian: _____ Printed Name: _____ Date: _____