

**Health History and Examination Form for Children and Adults Attending Camp**

Dates of Camp Attendance \_\_\_\_\_

Return this form by May 1<sup>st</sup> to: **Stonybrook Day Camp**  
**42 Park Ave.**  
**Randolph, NJ 07869**

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians of minors, or by adults themselves. Update required annually. **Health exam (back page) must be completed by approved licensed medical personnel each year.**

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_  
Last First Middle

Home address \_\_\_\_\_  
Street address City State Zip

Social security number of participant \_\_\_\_\_ Gender:  Male  Female

**Custodian parent/guardian** \_\_\_\_\_ Phone \_\_\_\_\_

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

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Second parent or guardian or emergency contact** \_\_\_\_\_

Home address \_\_\_\_\_  
Street address City State Zip

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**If not available in an emergency, notify** \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street address City State Zip

**\* IMPORTANT – THIS BOX MUST BE COMPLETED FOR ATTENDANCE \***

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp 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 or guardian, or adult staff **(must be signed by someone 18 or over)** \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

I give my permission to the camp Health Manager to give my child a weight/age appropriate dosage of Benadryl for a severe allergic reaction (parents will be notified immediately):

**Parent's Signature Required** \_\_\_\_\_

**Trailblazers Only:** I give my permission for the Trailblazers designated Healthcare Manager, to dispense all prescribed medications on all off-site camp trips.

**Parent's Signature Required** \_\_\_\_\_

I give my permission to the camp Health Manager to give my child a weight/age appropriate dosage of Tylenol for temperature greater than 101° (parents will be notified immediately):

**Parent's Signature Required** \_\_\_\_\_

**TeenXtreme Only:** I give my permission for the TeenXtreme designated Healthcare Manager, to dispense all prescribed medications on all off-site camp trips.

**Parent's Signature Required** \_\_\_\_\_

**HEALTH HISTORY/INSURANCE**

The following information must be filled in by the parent/guardian, 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 health personnel upon participant’s arrival in camp. Provide complete information so that the camp can be aware of your needs.

**INSURANCE INFORMATION**

(\*Photocopy of front and back of health insurance card must be attached to this form)

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

If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

**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 non-prescription 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 the frequency of administration.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Medication #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Medication #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Attach additional pages for more medications, if necessary.

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.

**Dietary**

Does not eat red meat

Does not eat pork

Does not eat eggs

Does not eat poultry

Does not eat seafood

Does not eat dairy products

Other (describe) \_\_\_\_\_

**Explain any restriction 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
1. Had any recent injury, illness or infectious disease? .....	[ ]	[ ]	15. Ever been diagnosed with a heart murmur? .....	[ ] [ ]
2. Have a chronic or recurring illness/condition? ....	[ ]	[ ]	16. Ever had back problems? .....	[ ] [ ]
3. Ever been hospitalized? .....	[ ]	[ ]	17. Ever had problems with joints (knees, ankles)? .....	[ ] [ ]
4. Ever had surgery? .....	[ ]	[ ]	18. Have an orthodontic appliance being brought to camp? .....	[ ] [ ]
5. Have frequent headaches? .....	[ ]	[ ]	19. Have any skin problems (itching, rash, acne)? .....	[ ] [ ]
6. Ever had a head injury? .....	[ ]	[ ]	20. Have diabetes? .....	[ ] [ ]
7. Ever been knocked unconscious? .....	[ ]	[ ]	21. Have asthma? .....	[ ] [ ]
8. Wear glasses, contacts or protective eye wear? .....	[ ]	[ ]	22. Had mononucleosis in the past 12 months? .....	[ ] [ ]
9. Ever had frequent ear infections? .....	[ ]	[ ]	23. Had problems with diarrhea/constipation? .....	[ ] [ ]
10. Ever passed out during or after exercise? .....	[ ]	[ ]	24. Have problems with sleepwalking? .....	[ ] [ ]
11. Ever been dizzy during or after exercise? .....	[ ]	[ ]	25. If female, have an abnormal menstrual history? .....	[ ] [ ]
12. Ever had seizures? .....	[ ]	[ ]	26. Have a history of bed-wetting? .....	[ ] [ ]
13. Ever had chest pain during or after exercise? .....	[ ]	[ ]	27. Ever had an eating disorder? .....	[ ] [ ]
14. Ever had high blood pressure? .....	[ ]	[ ]	28. Ever had emotional difficulties for which professional help was sought? .....	[ ] [ ]

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

---



---



---

Which of the following has the participant had?

- |                                      |                                      |   |  |
|--------------------------------------|--------------------------------------|---|--|
| <input type="checkbox"/> Measles     | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> German Measles | <input type="checkbox"/> Mumps           |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C    | <input type="checkbox"/> Rheumatic Fever |

TB Mantoux Test: Date of last test \_\_\_\_\_ Result:  Positive  Negative

**Please give all dates of immunizations**

**NOTE: ALL DATES MUST BE GIVEN IN MONTH/DAY/YEAR FORMAT!**

Vaccine:	<u>Mo/Day/Yr</u>	<u>Mo/Day/Yr</u>	<u>Mo/Day/Yr</u>	<u>Mo/Day/Yr</u>	<u>Mo/Day/Yr</u>	<u>Mo/Day/Yr</u>
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
or Measles	_____	_____	_____	_____	_____	_____
or Mumps	_____	_____	_____	_____	_____	_____
or Rubella	_____	_____	_____	_____	_____	_____
Haemophilus influenza B	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____	_____

**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.**

---



---



---



---

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL**

I examined this individual on \_\_\_\_\_. Exams must be within **12 months** of camp attendance.  
A new exam is not necessarily required for camp attendance.

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant  **is** able to participate in an active camp program  
 **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 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 the camp \_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE OF LICENSED MEDICAL PERSONNEL** \_\_\_\_\_

Printed name \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

***For camp use only***

**Screening Record**

Date screened \_\_\_\_\_ Time \_\_\_\_\_ am  
pm

Meds received \_\_\_\_\_  
\_\_\_\_\_

Updates/additions to health history noted  Yes  No  None required

Current health needs identified \_\_\_\_\_  
\_\_\_\_\_

Observational notes \_\_\_\_\_  
\_\_\_\_\_

Screened by \_\_\_\_\_