



Camp Tapawingo Health Form

Counselor in Training

Session: _____

Counselor in Training Information (Please print clearly)

Name (Last) _____ (First) _____ (M.I.) _____ Birth Date ____/____/____ Age at camp ____

Address _____ (City) _____ (State) _____ (Zip) _____ Phone(____) _____

Social Security number of camper _____ Gender: Female

Mother's Name _____ Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ Email Address _____

Father's Name _____ Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ Email Address _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone (____) _____

Physician/Pediatrician _____ Phone (____) _____

Orthodontist _____ Phone (____) _____

Dentist _____ Phone (____) _____

INSURANCE INFORMATION

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

If so, indicate Insurance Company: _____

Group # _____ Prescription Plan # _____

Name of insured _____ Relationship to participant _____

PLEASE INCLUDE A PHOTOCOPY OF HEALTH INSURANCE CARD TO BE USED IN THE EVENT THAT MEDICAL TREATMENT OR PRESCRIPTION IS REQUIRED.

Parent Authorization and Permission to Provide Necessary Treatment or Emergency Care

(MUST be completed before child can be admitted to camp)

This health history is correct and complete as far as I know and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by Camp Tapawingo to order X-rays, routine tests, and/or seek emergency medical treatment. I agree to the release of any records necessary for insurance purposes and give my permission to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director and/or his/her Assistant(s) to secure and administer treatment, including hospitalization, for the person named above. The completed form may be photocopied for trips out of camp. I authorize any physician, nurse or other health care provider to communicate with the medical staff and director of Camp Tapawingo, or her designee, about my child's medical condition, treatment, and/or prognosis. We further authorize the camp medical staff to discuss any medical conditions with the director, her designee, or the child's counselor when the medical staff, in its sole discretion, believes such communication to be in the best interest of the child. These authorizations are limited to June 1, 2009 through August 22, 2009. The completed form may be photocopied for trips out of camp.

Signature of Parent _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of C.I.T. _____ Date _____

HEALTH HISTORY

ALLERGIES (List all known)

		Describe reaction and management of the reaction
Medication	1.	1.
	2.	2.
Food	1.	1.
	2.	2.
Other		

General Questions (Explain "yes" answers below)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had a heart defect or disease	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Ever had problems with joints (ex. knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have any skin problems (ex. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have problems sleep-walking?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have a history of bedwetting?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	29. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever had measles, chicken pox, german measles, or mumps?	<input type="checkbox"/>	<input type="checkbox"/>	30. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>

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

Use the space below to provide any additional information about the participant's behavior of which the camp should be aware.

Physical Examination - To be filled out by Physician

Each camper must have had a physical examination by a physician within 12 months of the camper's week(s) at camp.

Camper Name _____ Date of Birth ____/____/____
Last *First*

I have examined the above camp participant. Date of examination _____

B/P _____ Weight _____ Height _____ Urine _____ Vision _____

Eyes: _____	Posture/Spine: _____
Ears: _____	Skin: _____
Nose: _____	Hernia: _____
Throat: _____	Teeth: _____
Heart: _____	Abdomen: _____
Lungs: _____	

IMMUNIZATION HISTORY:

DPT or DR or TD	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Polio	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Tetanus	Date: _____				
Measles	Date: _____				
Mumps	Date: _____				
Rubella	Date: _____				
Chicken pox/varicella	Date: _____				
Haemophilus influenza B	Date: _____				
Hepatitis B	Date: _____				
Hepatitis A	Date: _____				
TB Mantoux Test	Date of last Test: _____	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative		

RECOMMENDATIONS WHILE AT CAMP:

Special Diet: _____

Medications:

- This person takes NO medications on a routine basis.
- This person takes medications as follows:
 (Any medication prescriptions must arrive in the original containers with the pharmacy label attached)

Medication	Dosage	Specific times taken each day	Reason for taking
1.			
2.			
3.			

Activity Restrictions: _____

Additional Information for Health Care

Staff: _____

New York State Law requires this section to be filled out by a physician in order for our Health Director to dispense over-the-counter, non-prescription medication to your child when needed.

MEDICATION	DOSAGE SCHEDULE	AGREE WITH ORDER	COMMENTS
Acetaminophen Liquid, Chewable, or Tablet	Per label instructions by age/weight	YES / NO	
Ibuprofen Liquid, Chewable, or Tablet	Per label instructions by age/weight	YES / NO	
Cough Suppressants	Per label instructions by age/weight	YES / NO	
Pepto Bismol	Per label instructions by age/weight	YES / NO	
Antacids	Per label instructions by age/weight	YES / NO	
Kaepectate or Immodium AD	Per label instructions by age/weight	YES / NO	
Benadryl Capsules Oral for allergic reactions	Per label instructions by age/weight	YES / NO	
Chlor-trimeton	Per label instructions by age/weight	YES / NO	
Topical Antibiotics Bacitracin, Neosporin	Per label instructions	YES / NO	
Silvadene Cream	Per label instructions	YES / NO	
Topical Antipruritics Caladryl Lotion	Per label instructions	YES / NO	
Visine-eyes	Per label instructions	YES / NO	
Anbesol: tooth pain	Per label instructions	YES / NO	
OTC RID or NIX For lice	Per label instructions	YES / NO	
Epi Pen: Anaphylactic bee stings/allergies	Per camp medical direction	YES / NO	
Albuterol Inhalation Sol .83% History of asthma or difficulty breathing	Per camp medical direction	YES / NO	
Oxygen	Per camp medical direction	YES / NO	
Other:			
Other:			

***If there are other over-the-counter, non-prescription medications that the camper takes, physician must include each one in the table above, or we will not be able to give them to your child.**

I have examined the patient herein described and have reviewed the health history and understand the physical demand of the wilderness hiking trip. It is my opinion that this child is physically able to engage in the Counselor in Training wilderness trip.

Physician's Signature _____ Date: _____

Please Print Name _____ Phone Number _____

Address _____