

Health History and Examination Form for Children, Youth and Adults

Dates of Camp Attendance _____

Attending Camps **FM08N**

Suggested for resident camp use.

Developed and approved by American Camp Association with the American Academy of Pediatrics

Mail this form to the address below by _____ (date):

**Cazadero Performing Arts Camp
P.O. Box 7908
Berkeley, CA 94707**

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 at least every two years.

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

Custodial parent/guardian _____ Phone _____

Home address _____
(if different from above) Street Address City State Zip

Business address _____
Street Address City State Zip

Second parent or guardian or emergency contact _____

Address _____ Phone _____
Street Address City State Zip

Business address _____ Phone _____
Street Address City State Zip

If not available in an emergency, notify _____

Relationship _____ Phone _____

Address _____
Street Address City State Zip

Insurance information

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

If so, indicate carrier or plan name _____ Group # _____

Photocopy of front and back of health insurance card must be attached to this form.

Important — These boxes must be completed for attendance*

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 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 purpose 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/guardian or adult camper/staffer _____

Printed Name _____ Date _____

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

Signature of minor or adult camper/staffer _____ Date _____

*If for religious reason you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Cabin or Group: _____

Name: _____

Health History

The following information must be filled in by the parent/guardian, or adult camper 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.

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 nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep 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 medication 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.

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

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (ACA accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for 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 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 _____ Title _____

Address _____

Phone _____ Date _____

For camp use only

Screening record

Date screened _____ Time _____ am

Meds received _____ pm

Updates/additions to health history noted Yes No None required

Current health needs identified _____

Observational notes _____

Screened by _____