



For Camp Use Only

Camp#: _____
 Housing: _____
 Counselor: _____

HEALTH HISTORY FORM -

Pocono Plateau Camp

(To be completed and signed by parent/guardian. Please print or type all entries)

Bring completed form along to camp at check in - **PLEASE DO NOT MAIL.**

GENERAL INFORMATION

CAMPER'S NAME: _____ Name Preferred: _____
 Last First MI

Date of Birth: _____ Age: ____ Sex: M F Grade completed by June: ____ Height ____ Weight: ____

Address: _____ City: _____ State: ____ Zip: _____

Name of Parent/Guardian: _____ Home Phone: (____) _____

Parent/Guardian Work Phone: Mother: (____) _____ Father: (____) _____

Mother cell: (____) _____ Father cell: (____) _____

IN CASE OF EMERGENCY, PLEASE NOTIFY (*indicate by number the order desired: 1, 2, 3*). Parents/Guardians will be notified of camper illness/injury if the condition warrants outside medical attention, or involves a fever for more than 24 hours.

() Parent/Guardian named above

() _____ Relationship to camper _____ Phone: (____) _____
 Relationship

() _____ to camper _____ Phone: (____) _____

PHYSICIAN'S NAME: _____ Phone: (____) _____
 (Please Print)

Family Medical/Hospitalization Insurance: _____

Policy ID #: _____ Policy/Group #: _____ Policy Holder SS #: _____

(This information is required since each camper is covered by limited accident and medical insurance - in excess of parents own insurance; **THE CAMP'S POLICY IS A SECONDARY POLICY. PA state law prohibits duplicate payments.**)

IMMUNIZATIONS

Are all immunizations up to date? Yes ____ No ____

Date of last Tetanus (DPT, DT, DTaP, Td, Tdap) (*Circle latest ones that apply*). Date **MUST** be listed here: _____

DATE OF CAMPER'S LAST HEALTH EXAM _____

Were any problems noted at that time? _____

Is camper currently under a physician's care for a medical problem? Y N Explain: _____

Does camper regularly take medications during the school year? Y N Medication(s): _____

PLEASE FILL OUT A SEPARATE 'AUTHORIZATION FOR MEDICATION' FORM FOR EACH MEDICINE BRINGING TO CAMP WHICH IS TO BE COMPLETED AND SIGNED BY YOUR PHYSICIAN.

Since camper's last health exam, has he/she had:

____ A serious injury requiring medical attention? Date: _____ What? _____

____ A surgical operation or fracture? Date: _____ What? _____

____ A diagnosed infectious/communicable disease? Date: _____ Disease: _____

____ Medication prescribed by a physician to be taken on a regular basis? Date: _____ What? _____

____ A physician's restriction from participating in any school physical activity? _____

NOTE: A written statement from the camper's physician may be needed in order for your child to participate in strenuous camp activities such as swimming, boating, hiking, horseback riding, or sports if you checked any of the above questions.

ILLNESSES AND INJURIES (Check those that apply)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Heart Disease/Defect | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Frequent Ear Infection | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Frequent Upper Respiratory Infections |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other (Specify) _____ |

ALLERGIES (Check those that apply)

- | | | | |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Animals | <input type="checkbox"/> Foods | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Seasonal/Environmental |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Plants (Poison Ivy, etc) | <input type="checkbox"/> Other (Specify) _____ | |

Please explain any allergies checked above and list treatment if any is necessary:

OTHER HEALTH CONDITIONS (Check those that apply)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Ear Tubes (How protected) |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Previous Homesickness |
| <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Ringworm |
| <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Stomach Upsets | <input type="checkbox"/> Wears Glasses/Contacts | <input type="checkbox"/> Special Dietary Regimen |

Please explain any of above checked items or other conditions not mentioned: _____

CAMPER MEDICATIONS

ALL camper medications will be checked by the Camp Health Supervisor upon arrival. The Health Care Supervisor will insure that medications are administered in accordance with physician's instructions. For these purposes, **Medication** is broadly defined to include prescription and non-prescription medications, home remedies, vitamins, inhalers, drops, and medicated creams. Limited types of common over-the-counter medications are available at each camp. We ask your full cooperation in this matter so that every camper's health and well being can be properly safeguarded. **Please complete one 'Authorization For Medication Administration' form for each medication.** You may copy the form.

NO MEDICATION WILL BE GIVEN WITHOUT THIS COMPLETED MEDICATION FORM!

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

CERTIFICATION AND AUTHORIZATION

I certify that the information provided on both sides of this Health History Form is, to the best of my knowledge, complete and accurate. I know of no reason(s), other than the information indicated on this form why my son/daughter should not participate in all camp activities. I take full responsibility for any medical problems (illness or injury) that occur as a result of my failure to disclose medical condition, restrictions, or limitations of my child. I understand the State of Pennsylvania requirement that all campers be examined by the Health Care Supervisor on the day of registration and give my permission for the conduct of such an examination.

My son/daughter _____, has permission to participate in the activities associated with the summer camping program of the Eastern Pennsylvania Conference/United Methodist Church. Further, in the event of an illness or emergency, the Program Center Director or designee is authorized to act in my behalf in securing medical treatment for my child names above.

Signature of Parent/Guardian _____ Date: _____

FOR CAMP USE ONLY:

ON-SITE HEALTH EXAMINATION

General Health Condition: _____

Illness experienced or exposed to during preceding 30 days: _____

Recommendations and restrictions (activity, diet, etc.) _____

Counselor advised of any above conditions: _____

Signature of Camp Health Supervisor: _____ Date: _____