CAMP SCATICO

SUMMER 2020

HEALTH HISTORY AND EXAMINATION FORM FOR PARTICIPANTS UNDER 18 YEARS OF AGE

Parent/Guardian to sign pages 1-3; Physician to sign pages 2-4.

Name_____ DOB_____ Age on 6/1/20____ Gender _____
Last *First* *Month / Day / Year*

Address_____
Street Address *City* *State* *Zip*

Parent(s)/Guardian(s) that must be contacted in case of illness or injury

Name_____ Relationship _____ **cell** _____ **home** _____ **work** _____

Name_____ Relationship _____ **cell** _____ **home** _____ **work** _____

Additional emergency contact in event neither listed above can be reached

Name_____ Relationship_____ Phone _____

Insurance Information: attach a copy of front & back of an insurance, FSA and/or HSA card

Policy Holder_____ SS#_____ DOB_____

Policy Holder's Employer _____

Insurance Company_____ Phone _____

Insured ID#_____ Group # _____

Credit Card: Attach a copy of front and back of a credit card for medical expenses not covered by insurance

Physician Information (Indicate the doctor(s) we should contact if necessary)

Physician/Pediatrician _____ Phone _____

Other _____ Phone _____

PERMISSION TO PROVIDE NECESSARY TREATMENT AND TO RELEASE MEDICAL INFORMATION:

I hereby give permission to the camp to provide routine health care, administer or dispense prescription and over-the-counter medications and seek medical treatment including ordering diagnostic tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes and to provide or arrange necessary transportation for my child. I authorize any physician, nurse or health care provider to communicate with the medical staff and directors of Camp Scatico, or their designees, about my child's medical condition, treatment, and/or prognosis. I further authorize the camp medical staff to discuss any medical conditions with the directors, or their designees, or my child's counselor, when the medical staff, in its sole discretion, believes such communication to be in the best interest of my child or in the best interest of the camp community. In the event that I, or any of the contacts listed above, cannot be reached in case of an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child. This completed form may be photocopied for trips out of camp and transmitted electronically when needed. I also agree to abide by the restrictions placed on my child's camp activities.

Print Name_____ Signature_____ Relationship_____ Date _____

PARENT SIGN HERE

NAME OF PARTICIPANT UNDER 18 YEARS OLD: _____Summer 2020

The following information must be filled in by a parent or guardian and reviewed and signed by a physician prior to arrival at camp. The camp health personnel must be informed of any changes to this form upon arrival at camp.

Medical/Surgical History: Please list any current or past medical problems, hospitalizations, or surgical procedures your child has undergone, with further explanations as necessary or specify NONE if appropriate.

_____

_____

Medications: The camp is requiring that participants subscribe to *CampMeds*.
List all medications—*prescription and over-the-counter*—to be taken during camp, *even those only taken on an "as needed" basis.* Specify NONE if appropriate: **This person receives regular allergy shots** ___Yes ___No

Name of Medication	Frequency and Dosage	Reason for Taking

Medication Restrictions: Camp physicians may prescribe over the counter medications at their discretion. Please list if there are any medications (Tylenol, Motrin, Claritin, etc.) which you will not permit.

_____

_____

Medication Allergies: List any medication allergies and describe reaction or specify NONE if appropriate.

Medication	Reaction

Non-Medication Allergies: Please List any non-medication allergies (Food, Insect bites, etc.) and describe reaction or specify NONE if appropriate.

Allergen	Reaction

Diet, Nutrition: Participant
___ eats a regular diet ___ eats a vegetarian diet ___ is lactose intolerant ___ is gluten intolerant
___ Other, please explain _____

___ I consent to the use of **sunscreen and insect repellant** supplied by the participant or the camp, which is approved by the FDA for over the counter use. Unlicensed camp staff may assist this person.
___ I have reviewed the program and activities of the camp and feel the participant can participate without restrictions.
___ I have reviewed the program and activities of the camp and feel the participant can participate with the following adaptations: _____
_____

Parent/Guardian Signature and Physician Review. This health history is correct and complete as far as I know. Camp will be advised of any changes to this form upon arrival at camp.

Parent Print Name_____ Signature_____ Relationship_____ Date _____
PARENT SIGN HERE

Physician Print Name_____ Signature_____ Date _____
PHYSICIAN SIGN HERE

License #_____ Address_____ Phone _____

NAME OF PARTICIPANT UNDER 18 YEARS OLD: _____Summer 2020

Mental, Emotional, and Social Health:

Participant has been diagnosed with a condition that impacts learning (e.g. ADHD, sensory processing) ___Yes ___No

Participant has a psychiatric diagnosis (e.g. depression, panic/anxiety disorder, OCD) ___Yes ___No

Participant has an emotional health concern ___Yes ___No

If yes, please specify_____

During the past year, the participant saw or is seeing a professional to address mental/emotional concerns ___Yes ___No

Treatment to be continued at camp for medical and psycho-social conditions _____

Limitations or restrictions to camp activities or job duties _____

Use this space to provide any additional information about behavior, physical, emotional, or mental health about which the camp should be aware

_____

_____

_____

Place one check (✓) in the appropriate column that corresponds to each item below. *If "yes" provide details and date:*

	Yes	No		Yes	No		Yes	No
Recurrent/chronic illnesses			Diabetes			Diarrhea/Constipation		
Recent infectious disease			Skin Problems			Fainting/dizziness		
Traveled outside USA in past 9 months			Headaches			Falling Asleep/sleepwalking		
Recent injury			Frequent UTIs			Mononucleosis		
Asthma/wheezing/shortness of breath			Seizures			Bedwetting		
Wears glasses, contacts, or protective eyewear			Hepatitis A,B,C			Back/joint problems		
Passed out/chest pain during exercise			Lice			Period/Menstruation issues		

If answered "yes" pleased provide specific details

_____

_____

_____

New York State Public Health Law §2167 and Subpart 7-2 of the State Sanitary Code requires that everyone complete and submit the following information. Check one (1) box.

☐ Participant has had the meningococcal conjugate vaccine, for example, Menactra™ or Menveo™ **Date received** _____

☐ I have read or had explained to me the information regarding meningococcal meningitis disease and understands the risks of not receiving the vaccine and has decided not to obtain immunization against meningococcal meningitis disease.

Parent/Guardian Signature and Physician Review: This health history is correct and complete as far as I know. Camp will be advised of any changes to this form upon arrival at camp.

Parent Print Name_____Signature_____Relationship_____Date _____

PARENT SIGN HERE

Physician Print Name_____Signature_____Date _____

PHYSICIAN SIGN HERE

License #_____Address_____Phone _____

NAME OF PARTICIPANT UNDER 18 YEARS OLD: _____Summer 2020

TO BE COMPLETED BY PHYSICIAN WITHIN TWELVE MONTHS PRIOR TO ARRIVAL AT CAMP

Date of Exam_____Ht._____Wt._____Pulse_____BP_____

Immunization Record (You can attach a separate copy.)	**Dose 1 Month/Year**	**Dose 2 Month/Year**	**Dose 3 Month/Year**	**Dose 4 Month/Year**	**Dose 5 Month/Year**	**Most Recent Dose Month/Year**
Diphtheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster (dT) or (TdaP)						
Mumps, measles*, rubella (MMR)						
Polio (IPV)						
Pneumococcal						
Hemophilus (HIB)						
Hepatitis B						
Hepatitis A						
Varicella						

***Camp Scatico is requiring that all campers and staff be vaccinated against measles except for those with medical exemptions as defined by the Americans with Disabilities Act. If you have any questions or believe that the participant falls within this exemption, please contact us immediately. The New York State Department of Health strongly recommends that for maximum protection all participants have two doses of the measles, mumps, and rubella (MMR) vaccine.**

Also, we ask that you notify us if there has been a direct exposure to someone with measles within 21 days prior to the start of camp.

Had Chicken Pox __Yes __No	Date:	Had Measles __Yes __No	Date:	Had Mumps __Yes __No	Date:	TB test __ Negative __ Positive	Date

Diet and Nutrition: Participant ___ eats a regular diet. ____ has a medically prescribed meal plan or dietary restrictions as described below:

_____

Participant is undergoing treatment at this time for the following conditions as described below: __None

_____

Other treatments/therapies to be continued at camp as described below: __None needed

_____

Do you feel that the participant will require limitation or restrictions to activity while at camp? __ Yes __ No

If yes, what do you recommend? _____

Medical Personnel Authorization I have reviewed the Camper Health History Form and have discussed the camp program with the participant's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Print Name_____Signature_____Date _____

PHYSICIAN SIGN HERE

License #_____Address_____Phone _____

Reviewed and Screened by Camp Scatico Health Care Provider: _____

Name Signature Date