Mail or Fax this form to the address below by June 1.

WV Summer Camp
124 Coventry Lane
North Andover MA 01845 **Fax 978-824-7509**

Health History and Examination Form for Campers and Staff

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 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 ____ Phone_________________________
Street Address City State Zip

Second parent or guardian or emergency contact ____

Address____ Phone_________________________
Street Address City State Zip

Business address ____ Phone_________________________

If not available in an emergency, notify ____

Relationship ____ Phone_________________________

Address____
Street Address City State Zip

Insurance Information

Is the participant 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 — This section 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 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_______________________

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.______________________

____

MEDCATIONS 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 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**:

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 poultry
- [ ] Does not eat red meat
- [ ] Does not eat pork
- [ ] Does not eat seafood
- [ ] Does not eat dairy products
- [ ] Does not eat eggs

Other (describe)____

____

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

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____

____

General Questions (Explain "yes" answers below.)

Has/does the participant:	YES	NO
Had any recent injury, illness or infectious disease?		
Have a chronic or recurring illness/condition?		
Ever been hospitalized?		
Wear glasses, contacts or protective eye wear?		
Have frequent headaches?		
Ever had a head injury?		
Ever been knocked unconscious?		
Ever had seizures?		
Ever had frequent ear infections?		
Ever had chest pain during or after exercise?		
Ever been diagnosed with a heart murmur?		
Ever had problems with joints (e.g., knees, ankles)?		
Had problems with diarrhea/constipation?		
If female, have an abnormal menstrual history?		

	YES	NO
Ever had back problems?		
Ever had surgery?		
Ever passed out during or after exercise?		
Ever been dizzy during or after exercise?		
Have any skin problems (e.g., itching, rash, acne)?		
Have diabetes?		
Have asthma?		
Ever had high blood pressure?		
Ever had an eating disorder?		
Have a history of bed-wetting?		
Had mononucleosis in the past 12 months?		
Have an orthodontic appliance being brought to camp?		
Ever had emotional difficulties for which professional help was sought?.		
Have problems with sleepwalking?		

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

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Which of the following has the participant had?

___Measles
___Chicken pox
___German measles
___Mumps
___Hepatitis A
___Hepatitis B
___Hepatitis C

TB Mantoux Test
Date of last test______________
Result __Positive __ Negative

Please give all dates of immunization for:

Vaccine Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
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.

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____

____

____

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 ___________ (WVCS requirements specify exams within 24 months of 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/ pm

Meds received

____

____

Updates/additions to health history noted __Yes ___No ____None required

Current health needs identified____

____

Observational notes____

____

Screened by_________________________________