

Completed form MUST be submitted with registration.

For Office Use

Health History & Examination Form

for children, youth and adults attending Sprucelands Equestrian Camp.

Dates of Camp Attendance: _____

Registrar: <input type="checkbox"/> Summer Camp <input type="checkbox"/> Session 1 Sprucelands Equestrian Camp <input type="checkbox"/> Session 2 Po Box 54 <input type="checkbox"/> Session 3 1316 Pit Road <input type="checkbox"/> Session 4 Java Center, NY 14082

Developed and approved by the *American Camping Association*® and the *American Academy of Pediatrics*

The information on this form is not part of the camper or staff acceptance process, but gathered to assist us in identifying appropriate care. **Health history (first two pages) must be filled out**

by parents/guardians of minors or by adults themselves. Update required annually. **Health exam (page 3) must be completed by approved licensed medical personnel** at least every two years.

Name: _____ Birth Date _____ Age at camp _____
Last First Middle

Home Address _____

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, 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:

Name _____

Relationship _____ Phone _____

Address _____
Street Address City State Zip

Important - These boxes must be completed for attendance*

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.**

<p>Parent/Guardian Authorizations: This health history is correct and complete to the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted.</p> <p>I hereby give my permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance</p>	<p>purposes. I give permission to the camp to arrange necessary related transportation for me/my child.</p> <p>In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Sprucelands to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.</p>
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 parent/guardian or adult camper/staffer _____ Date _____

Year

Cabin or Group

Name

Health History

Allergies

List all known allergies. Describe reaction and management of reaction.

No known allergies

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 _____

Activities Please explain any (e.g. what cannot be done, what adaptations or limitations are necessary)

General Questions (Explain "yes" answers below)

YES NO

Has/does the participant:

YES NO

1. Had any recent injury, illness or infectious disease?

2. Have a chronic or recurring illness/condition?

3. Ever been hospitalized?

4. Ever had surgery?

5. Have frequent headaches?

6. Ever had a head injury?

7. Ever been knocked unconscious?

8. Wear glasses, contacts, or protective eye wear?

9. Ever had frequent ear infections?

10. Ever passed out during or after exercise?

11. Ever been dizzy during or after exercise?

12. Ever had seizures?

13. Ever had chest pain during or after exercise?

14. Ever had high blood pressure?

15. Ever been diagnosed with a heart murmur?

16. Have an orthodontic appliance brought to camp?

17. Have any skin problems (e.g. itching, rash, acne)?

18. Have diabetes?

19. Have asthma?

20. Had mononucleosis in the past 12 months?

21. Had problems with diarrhea/constipation?

22. Ever had an eating disorder?

23. If female, have an abnormal menstrual history?

24. Ever had problems with joints (e.g. knees, ankles?)

25. Ever had back problems?

26. Ever had emotional difficulties for which professional help was sought?

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

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.

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Physician's Section

I examined _____ on _____ (ACA accreditation 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:

Medications to be administered at camp: Place initials in yes/no box for authorization of standard over-the-counter medications to be administered at the discretion of the RN. Please write out any other **over-the-counter or prescription medications in the remaining space.** Must include medication name, route, dose, frequency, and duration to be administered at camp.

- Yes No Tylenol PO per label instructions by age/weight Q4H PRN for pain or fever > 100.5

- Yes No Ibuprofen PO per label instructions by age/weight Q6H PRN for pain or fever >101.5

- Yes No Sudafed PO per label instructions by age/weight Q4H PRN for nasal congestion not to exceed 4 doses in 24-hours

- Yes No Ludens Throat Lozenges PO per label instructions by age/weight for cough

- Yes No Robitussin PO per label instructions by age/weight Q4H PRN for cough

- Yes No Calamine Lotion TOPICAL per label instructions for allergic reactions/pruritus

- Yes No Benadryl PO per label instructions Q6H PRN for allergic reactions

Other Medications: _____

Treatments to be continued at camp: _____

Known Allergies: _____

Description of any limitations or restrictions on camp activities: _____

Check box if the participant has had:

- Measles Chicken Pox German Measles Mumps Hepatitis A B C

Please give dates of immunization:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DPT	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
Measles or	_____	_____	_____	_____	_____	_____
Mumps or	_____	_____	_____	_____	_____	_____
Rubella	_____	_____	_____	_____	_____	_____
Haemophilus Influenza B	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____	_____
Meningitis	_____	_____	_____	_____	_____	_____
TB Mantoux Test Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date of last test _____						

Signature of Licensed Medical Personnel: _____
 Printed: _____ Title: _____
 Address: _____
 Phone: _____ Date: _____

Marcia Dodge, RN
Health Care Administrator
 Sprucelands Equestrian Camp
 Po Box 54
 1316 Pit Road
 Java Center, NY 14082
 Phone (585) 457-4150
 E-mail: spruceland@aol.com
 Subject: Nurse

