

Corporate Address:  
60 Sandy Cove Rd  
North East, MD 21901  
Phone: (410) 287-5433  
Fax: (410) 287-3196



# Camp Sandy Cove

## HEALTH HISTORY/EXAMINATION FORM FOR CAMPERS AND STAFF



Summer Address:  
RT 1 Box 471  
High View, WV 26808  
Phone: (304) 856-2959  
Fax: (304) 856-1683

PLEASE PRINT BLACK INK ONLY AND APPLY ENOUGH PRESSURE TO PRINT ON A PRESSURE SENSITIVE COPY  
PLEASE FILL IN ALL SPACES WITH THE REQUESTED INFORMATION  
PLEASE BRING THIS COMPLETED FORM TO CAMP WITH YOU ON REGISTRATION DAY

Camper Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  M  F Age \_\_\_\_\_  
 Last First Initial

Parent/Guardian \_\_\_\_\_  
 Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Street & Number City State Zip Area Code & Number

Business Phone \_\_\_\_\_ Cell Phone/Beeper \_\_\_\_\_  
 Area Code & Number Area Code & Number

2nd Parent/Guardian if applicable \_\_\_\_\_  
 Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Street & Number City State Zip Area Code & Number

Business Phone \_\_\_\_\_ Cell Phone/Beeper \_\_\_\_\_  
 Area Code & Number Area Code & Number

Emergency Contact's Name (if parents cannot be reached): \_\_\_\_\_  
 Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Street & Number City State Zip Area Code & Number

**HEALTH HISTORY**  
 (Check - Give Approximate Dates)

Frequent Ear Infections  
 Heart Defect/Disease  
 Convulsions  
 Diabetes  
 Bleeding/Clotting Disorders  
 Hypertension  
 Mononucleosis  
 Psychiatric Treatment  
 Rheumatic Fever  
 Bed Wetting  
 Chicken Pox  
 Measles  
 German Measles  
 Mumps

(Dates not needed for the following)

Hay Fever  
 Ivy Poisoning  
 Insect Stings  
 Asthma  
 Penicillin  
 Food Allergies (list below):  
 \_\_\_\_\_

Drug Allergies (list below):  
 \_\_\_\_\_

Other (specify)  
 \_\_\_\_\_

Has the camper ever required any psychiatric counseling or hospitalization? \_\_\_\_\_  
 If so, explain \_\_\_\_\_  
 Operations or serious injuries (dates) \_\_\_\_\_  
 Disability or chronic or recurring illness \_\_\_\_\_  
 Activity encouraged or limited by physician \_\_\_\_\_  
 Dietary modification \_\_\_\_\_  
 Other diseases or details of above \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_  
 Name of dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_  
 Date of last physician's examination \_\_\_\_\_  
 Suggestions on health-related information for camp personnel \_\_\_\_\_

Current medications (send with instruction by physician) \_\_\_\_\_

**FOR FEMALE CAMPERS**

Has this individual menstruated? \_\_\_\_\_ If no, has she been told about it? \_\_\_\_\_  
 If so, is her menstrual history normal? \_\_\_\_\_ Special Considerations \_\_\_\_\_

**INSURANCE INFORMATION**

I understand that my insurance carrier is responsible for bills incurred by my child. If said camper is not covered by an insurance policy, I am responsible.

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Signature: \_\_\_\_\_

**IMPORTANT - This box must be completed by parent/guradian if camper is to attend camp**

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.  
**Authorization for treatment:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp.

Signature of parent or guardian or staff member \_\_\_\_\_ Date \_\_\_\_\_  
 Witness \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide with the restrictions placed on my camp activities. Signature of minor \_\_\_\_\_

Camper's Name \_\_\_\_\_  
Date Examined \_\_\_\_/\_\_\_\_/\_\_\_\_  
Registered for: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

# IMMUNIZATION HISTORY

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

VACCINES	YEAR OF BASIC IMMUNIZATION	YEAR OF LAST BOOSTER
Diphtheria Pertussis (Whooping Cough) <b>DPT*</b> Tetnus Or	1. 2. 3.	1. 2.
Tetnus Diphtheria <b>TD*</b> Or		
Tetnus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German Measles, 3-day Measles)		
Other		
Tuberculin test given (most recent)		
Haemophilus influenza b (HIB)		

## TO BE COMPLETED BY A LICENSED PHYSICIAN

I have examined the above camper/staffer within the past year. Date Examined: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Abnormal Findings: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The camper/staffer is under the care of a physician for the following condition(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Treatment (include medications): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Explanation of any loss of consciousness, convulsions, or concussion: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does the camper/staffer have epilepsy?  YES  NO    Does the camper/staff member have diabetes?  YES  NO

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

Treatment to be continued at camp: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications to be administered at camp (specific dosages): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medically prescribed meal plan or dietary restrictions (where possible): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies (food, drug, plants, insects, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional Health Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any restrictions or limitations on specific activities (specify): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In my opinion the above camper/staffer's condition  does  does not preclude his/her participation in an active camp program.

Licensed Physician's Signature: _____							
Address: _____		City _____		State _____	Zip _____	Phone: _____	Area Code/Number _____
Date of Form Completion: _____		By: _____		Indicate completed by a nurse or physician's assistant.			

**TO BE COMPLETED AT CAMP WHEN THE CAMPER/STAFFER ARRIVES**

Weeks Attending:  Work Week  Training Week (for staff only)

Week 1  Week 2  Week 3  Week 4  Week 5  Week 6  Week 7

Date of Health Screening: \_\_\_\_\_ (please indicated if screened more than one time in a summer)

Throat: \_\_\_\_\_ Temperature: \_\_\_\_\_ Head: \_\_\_\_\_ Scrapes/Bruises: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Examined by: \_\_\_\_\_