



Camp Sandy Cove

HEALTH HISTORY FORM

PLEASE MAIL IN THE COMPLETED HEALTH HISTORY FORM AND DOCTOR'S PHYSICAL PRIOR TO ARRIVING AT CAMP

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

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

Camper Name _____ Birth Date ___/___/___ Sex M F Age _____
Last First Initial

Parent/Guardian _____ Phone _____
Area Code & Number

Home Address _____
Street & Number City State Zip

Business Phone _____ Cell Phone _____
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 _____
Area Code & Number Area Code & Number

Emergency Contact's Name & Relationship: _____
Contact this person if parents cannot be reached

Home Phone _____ Cell Phone _____

ALLERGIES

____ Hay Fever
 ____ Ivy Poisoning
 ____ Insect Stings
 ____ Food Allergies

____ Drug Allergies

Please select the dates your child will be attending:

____ 4/30-5/2/2010 ____ 6/27-7/4/2010 ____ 7/4-7/11/2010 ____ 7/11-7/18/2010
 ____ 7/18-7/25/2010 ____ 7/25-8/1/2010 ____ 8/1-8/8/2010 ____ 8/8-8/15/2010

Name of family physician _____
 Phone _____ Fax _____

Name of dentist/orthodontist _____
 Phone _____ Fax _____

MEDICAL 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.

Camper is covered by family medical/hospital insurance Yes No

Insurance Company: _____ Policy Number: _____

Subscriber: _____ Insurance Company Phone Number: _____
Name of Policy Holder

PARENT AUTHORIZATION FOR HEALTH CARE
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. 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. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of parent or guardian or staff member _____ Date _____

Relationship to camper: _____



Camper Name _____	Last First Initial	Birth Date ____/____/____
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IMMUNIZATION HISTORY

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) DPT* Tetnus Or	1. 2. 3.	1. 2.
Tetnus Diphtheria TD*		
Polio (IPV)		
Measles, Mumps, Rubella (MMR)		
Varicella/Chicken Pox (if had/give date)		
Hepatitis B		
Tuberculin test given (most recent)		
Haemophilus influenza b (HIB)		
Meningococcal Meningitis (MCV4)		

GENERAL HEALTH HISTORY

Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

- | | |
|--|---|
| 1. Ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have recurrent/chronic illnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Had a recent infectious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Had a recent injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Had asthma/wheezing?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Had seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Had headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Wear glasses or contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Ever been treated for ADD/ADHD? <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Ever been treated for emotional/behavioral difficulties? <input type="checkbox"/> Yes <input type="checkbox"/> No
13. Had fainting or dizziness? <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Passed out/had chest pain during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Had mononucleosis ("mono") during the past 12 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
16. If female, have problems with periods/menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
17. Have problems with falling asleep/sleepwalking? <input type="checkbox"/> Yes <input type="checkbox"/> No
18. Ever had back/joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
19. Have a history of bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
20. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
21. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
22. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|---|

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

MEDICATION

This camper will not take any medication while at camp.

This camper will take the following daily medication(s) at camp.

We require original pharmacy containers with labels which show the camper's name and how the medication should be given.

Please provide enough medication to last the entire time the camper is at camp.

Name of Medication	When it is given	Amount or dose given	How it is given
	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime		
	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime		
	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime		



Camper Name _____	Birth Date ____/____/____
Last First Initial	

TO BE COMPLETED BY A LICENSED PHYSICIAN

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

Height: _____ Weight: _____ Blood Pressure: _____

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

Current Treatment (include medications): _____

Treatment to be continued at camp: _____

Does the camper/staffer have epilepsy? Yes No Does the camper/staff member have diabetes? Yes No

Medications to be administered at camp (specific dosages): _____

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

Allergies (food, drug, plants, insects, etc.): _____

Any restrictions or limitations on specific activities (specify): _____

Do you feel that the camper/staff member will require limitations or restrictions while at camp? Yes No

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