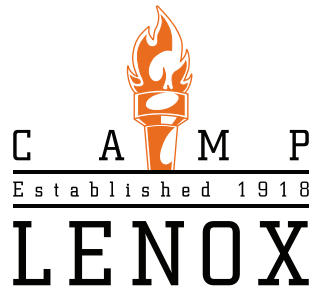


DIRECTORS  
RICHARD MOSS  
STEPHANIE MOSS  
MONTY MOSS



A TRADITIONAL  
SUMMER CAMP FOR  
BOYS & GIRLS  
AGES 7-16

## 2010 HEALTH HISTORY AND EXAMINATION

Name: \_\_\_\_\_ Cabin Group: \_\_\_\_\_ Attendance Dates: \_\_\_\_\_

Health history to be filled out by parents/guardians of minors or by adults themselves. Health examination to be completed by approved licensed medical personnel

### CAMPER/STAFFER INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Birthday: \_\_\_\_\_ Age at Camp: \_\_\_\_\_

Home Address: \_\_\_\_\_

City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Social Security Number of Camper/Staffer: \_\_\_\_\_ Gender: \_\_\_\_\_

Custodial Parent/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Home address: \_\_\_\_\_

City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Business address: \_\_\_\_\_ Phone: \_\_\_\_\_

2nd Parent/Guardian/Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Business address: \_\_\_\_\_ Phone: \_\_\_\_\_

If above not available in an emergency, notify:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE:** Is the participant covered by family medical/hospital insurance?  Yes  No

If yes, indicate carrier or plan name: \_\_\_\_\_

Group #: \_\_\_\_\_

**VERY IMPORTANT - A copy of the front and back of the health insurance card must be attached to this form**

WINTER ADDRESS **CAMP LENOX PO. BOX 75-9900 CORAL SPRINGS, FL 33075 TEL 954-340-6634 FAX 954-340-8282**  
SUMMER ADDRESS **CAMP LENOX 2042 N. MAIN ROAD LEE, MA 01238 TEL 413-243-2223 FAX 413-243-3446**



WWW.CAMPLNOX.COM



Camper/Staffer Name: \_\_\_\_\_

**VERY IMPORTANT – The following boxes must be complete for attendance**

**PARENT/GUARDIAN AUTHORIZATIONS:** This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give 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 treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

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/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: \_\_\_\_\_

\_\_\_\_\_

Food Allergies: \_\_\_\_\_

\_\_\_\_\_

Other allergies (include insect stings, hay fever, asthma, animal dander, etc.): \_\_\_\_\_

\_\_\_\_\_

**DIETARY RESTRICTIONS:**

Does not eat red meat

Does not eat poultry

Does not eat pork

Does not eat seafood

Does not eat eggs

Does not eat dairy products

Other (describe)

\_\_\_\_\_

Camper/Staffer Name: \_\_\_\_\_

**ACTIVITY RESTRICTIONS:** Please explain what cannot be done and any adaptations or limitations

\_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS 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: \_\_\_\_\_

Identify any medications taken during the school year that participant does/may not take during the summer (attach additional pages for more medications):

\_\_\_\_\_

**IMMUNIZATION RECORD:** Which of the following has the participant had?

- Measles                       Chicken Pox                       German Measles                       Mumps  
 Hepatitis A                       Hepatitis B                       Hepatitis C

Date of last TB Mantoux test: \_\_\_\_\_ Result:  Positive  Negative

Please give all dates of immunization for:

Vaccines	Dates					
DTP						
TD (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemophilus influenza B						
Hepatitis B						
Varicella (chicken pox)						

Camper/Staffer Name: \_\_\_\_\_

**GENERAL QUESTIONS:** Has/does the participant:

	Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have problems sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
25. If female, have abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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Camper/Staffer Name: \_\_\_\_\_

**PHYSICIAN INFORMATION:**

Name of family physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name of family dentist/orthodontist: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Specialist information (if applicable): \_\_\_\_\_

**HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL:** ACA accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.

I examined this individual on: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_

Weight: \_\_\_\_\_

Height: \_\_\_\_\_

In my opinion, the above applicant  is  is not able to participate in an active 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: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Camper/Staffer Name: \_\_\_\_\_

**SCREENING RECORD - FOR CAMP USE ONLY**

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: \_\_\_\_\_ Title: \_\_\_\_\_