# CAMP MABO & SOUND OF MUSIC

## Health History & Examination Form

## STAFF MEMBER

Name _____
Last First Middle
Birthdate _____Male_____ Female _____

Home address _____
City_____ State_____ Zip_____
Participant Social Security number_____
Custodial parent/guardian _____
Phone_____
Home address_____
(If different from above) City_____ State_____ Zip_____
Business address _____
Street address_____City_____ State____ Zip
If not available in an emergency, notify:
Name _____
Relationship _____ Phone _____

**Insurance Information**

Is the participant covered by family medical/hospital insurance? Yes__ No__
If so, indicate carrier or plan name _____
Group #
_____
Name of insured_____
Relationship to participant_____
Social Security number of policy holder or insurance ID _____

**IMPORTANT - THIS BOX MUST BE COMPLETED**

**Permission to provide necessary treatment or emergency care:**

I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related 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 the person named above. This completed form may be photocopied for trips out of camp. I also give permission to administer "over the counter" medicines, if needed. If you do not wish to authorize, a written statement to the nurse is required.

**Signature of parents or guardian**_____
**Date** _____

**List any known allergies to medications, food, insect stings, hay fever, asthma, animal, etc.**

_____

**Medications being taken**

Please list **all** medications takes routinely and reasons for taking them, keep it in the original packaging that identifies the prescribing physician (if a prescription drug) the name of the medication, the dosage, and the frequency of administration.

***Identify any medications taken during the year that he/she does not take during the summer.***

_____

Any restrictions in diet or activities? _____

**General Questions (Explain "yes" answers below)**

| Has the camper had? | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| 1. Had any recent injury, illness of infections disease? | | | 11. Ever had problems with joint (E.g. knees & ankles) | | |
| 2. Has a chronic of recurring illness/ conditions? | | | 12. Have any skin problems (E.g. itching, rash, acne) | | |
| 3. Have frequent headaches? | | | 13. Have diabetes? | | |
| 4. Ever had a head injury? | | | 14. Have asthma? | | |
| 5. Ever been knocked unconscious? | | | 15. Had mononucleosis in past 12 months? | | |
| 6. Wear glasses, contacts or protective eye wear? | | | 16. If female, have an abnormal menstrual history? | | |
| 7. Ever had frequent ear infection? | | | 17. Ever had emotional difficulties for which professional help was sough? | | |
| 8. Ever had chest pain during or after exercise? | | | | | |
| 9. Ever had high blood pressure? | | | | | |
| 10. Ever had back problem? | | | | | |

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

_____

**Is there any additional information about his/her behavior and physical, emotional, or mental? health which the camp should be aware?**

_____

Name of family physician _____
Phone _____ Address _____

Name of family dentist/orthodontist _____
Phone _____ Address _____

Parent/Guardian Authorization: This health history is correct and completed and this person has permission to engage in all camp activities.

Signed _____ Print _____

Name _____

**Health Care Recommendations should be filled by a Physician**

I have examined the above counselor. Date of examination _____

BP _____ Weight _____ Height _____

_____ He/she can participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

_____

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

_____

Which of the following has he/she had?

____ Measles
____ Chicken pox
____ German measles
____ Mumps
____ Hepatitis
____ Varicella zoster
____ Swine flu (H1N1)
____ Covid-19

Please give date for last immunization

| Date | Vaccine |
|---|---|
| _____ | DTP |
| _____ | TP (tetanus/diphtheria) |
| _____ | Tetanus |
| _____ | Polio |
| _____ | Measles (hard or red measles or rubella) |
| _____ | Rubella |
| _____ | Hemophilic influenza B |
| _____ | Hepatitis |
| _____ | Viruela |
| _____ | Rotashield |
| | Covid-19 first |
| | Covid.19 second |
| | Booster Covid-19 |

**Signature of Licensed Physician**_____
**Name Printed**_____
**License Number** _____ **Title** _____
**Address**_____
**Phone** _____ Date_____

**Rev. 03-14--2022**

**Name:** _____

# 2022



# Health History

# Staff Member