

**CAMP MABO & SOUND OF MUSIC**  
**Health History & Examination FORM FOR CAMPERS**

This form is to be filled by parents/guardians

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 camper 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 month?		
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 sought?		
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 camper. 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?	Please give date for last immunization	
	Date	Vaccine
___ Measles	_____	Vaccine
___ Chicken pox	_____	DTP
___ German measles	_____	TP (tetanus/diphtheria)
___ Mumps	_____	Tetanus
___ Hepatitis	_____	Polio
___ Varicella zoster	_____	Measles (hard or red measles or rubella)
___ Influenza	_____	Rubella
	_____	Hemophilic influenza B
	_____	Hepatitis
	_____	Smallpox
	_____	Rotashield
	_____	Covid-19 first
	_____	Covid-19 second
	_____	Covid-19 booster

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

2022



Health History

Camper

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