

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 to my son/daughter who is a minor.

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 him/her 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. Indicate if he/she takes any medication that might affect their ability to work as a camp counselor.*

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 chronic or 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 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 my permission to engage in all camp activities.

Signed _____ Print _____

Name _____ Phone _____

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?	Please give date for last immunization	
	Date	Vaccine
_____ Measles	_____	DTP
_____ Chicken pox	_____	TP (tetanus/diphtheria)
_____ German measles	_____	Tetanus
_____ Mumps	_____	Polio
_____ Hepatitis	_____	Measles (hard or red measles or rubella)
_____ Varicella zoster	_____	Rubella
_____ Swine flu (H1N1)	_____	Hemophilic influenza B
_____ Covid-19	_____	Hepatitis
_____ Booster Covid-19	_____	Viruela
	_____	Rotashield

Name: _____



Health History
Staff Member

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