

CAMP CHERITH® in the Carolinas Health Record

Camp
Use Only

Name _____
 Cabin _____
 Year _____
 Allergies Yes No
 Medications Yes No
 Medical Issues Yes No
 Restrictions Yes No

Personal Information

Name _____
Last First Middle Initial

Birth date _____ Age at camp _____ Grade entering next term _____ Male _____ Female _____

Home phone (_____) _____ Social Security number _____

Custodial parent/guardian _____ Relationship to camper _____

Home phone (_____) _____ Work phone (_____) _____ Cell phone (_____) _____

Family physician name _____ Phone (_____) _____

Family dentist name _____ Phone (_____) _____

Alternate Emergency Contact

Name _____ Relationship to camper _____

Home phone (_____) _____ Work phone (_____) _____ Cell phone (_____) _____

Insurance Information

Name of insurance company _____

Telephone number _____

Address of insurance company _____

Policyholder's name _____ Social Security number _____

Relationship to camper _____ Group or policy number _____

CAMP CHERITH in the Carolinas carries secondary accident insurance, which means that the camp's insurance will only be used after an individual has filed with his/her own insurance company.

Permissions

This health record is complete and accurate as far as I know. The person described in this record has permission to participate in all camp activities except as listed.

By signing below, I give permission to the camp to give me/my child routine health care, to distribute prescribed medications, and in an emergency, to seek medical treatment, including x-rays or routine tests. I give permission for the camp to provide transportation as necessary. I agree that any necessary medical records may be released for insurance purposes.

By signing below, I also give permission to the physician selected by the camp to secure and provide treatment, including admission to a hospital, for the person named above, if I cannot be reached by telephone in an emergency situation.

Signature of parent/guardian or staff member _____

Printed name _____ Date _____

I understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of camper or staff member _____ Date _____

If for religious reasons you cannot sign this, contact the camp registrar for a legal waiver which must be signed for attendance.

Physical Examination by Licensed Medical Personnel

Name of camp participant _____
 Examination date _____ (must be within 24 months of attending camp).
 Height _____ Weight _____ BP _____ Allergies _____

The above named individual is under the care of a physician for the following conditions:

Continue the following treatment at camp:

Limitations or restrictions on camp activities:

List any additional information including medically-prescribed meal plan or dietary restrictions:

Administer the following medications at camp:

Name of Medication	Dosage	Route	Frequency	Condition for which medication is prescribed	Comments

List all immunization dates or attach the Florida HRS Certificate of Immunization Record.

Vaccine	Date	Date	Date	Date	Date	Date	Which of the following has the participant had?
DTP							Measles _____ Hepatitis A _____
TD							
Tetanus							Chicken pox _____ Hepatitis B _____
Polio							
MMR							Mumps _____ Hepatitis C _____ German measles _____
Or Measles							
Or Mumps							
Or Rubella							TB Mantoux test Date of last test _____ Result _____ Positive _____ Negative
Haemophilus							
Influenza B							
Hepatitis B							
Varicella (chicken pox)							

In my opinion, the above named individual is able to participate in an active camp program, with any restrictions or limitations listed above: Yes No

Signature of licensed medical personnel _____

Printed name _____

Address _____

Phone number (_____) _____ Date _____

Health History

Allergies: List all allergies including medications, food, insect stings, hay fever, asthma, animal dander, etc.

Camper/staff member is allergic to:	Describe the reaction	Describe the management of the reaction
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Dietary Restrictions

Activity Restrictions

Medications – list all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Bring medication 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. Our camp nurse has common over-the-counter medications and these do not need to be sent to camp (i.e. Tylenol, Motrin, etc.).

All medications must be turned in on arrival.

NO MEDICATIONS ARE TO BE KEPT IN THE CABINS WITH CAMPERS UNLESS FIRST CLEARED.

Name of Medication	Dosage	Route	Frequency	Condition for which medication is prescribed	Comments

General Health Questions Check any conditions which the camper/staff member has now or has had and explain below.

<input type="checkbox"/> Recent injury, illness or infectious	<input type="checkbox"/> Chronic or recurring illness/condition	<input type="checkbox"/> Hospitalizations or surgeries
<input type="checkbox"/> Frequent or current ear infection	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Back problems
<input type="checkbox"/> Mononucleosis in the past 12 months	<input type="checkbox"/> Seizures	<input type="checkbox"/> Problems with joints (e.g. knees, ankles)
<input type="checkbox"/> Knocked unconscious	<input type="checkbox"/> Asthma	<input type="checkbox"/> Fractures/sprains/strains
<input type="checkbox"/> Head injury	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Problems with diarrhea or constipation
<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Problems with sleepwalking
<input type="checkbox"/> Chest pain during/after exercise	<input type="checkbox"/> Skin problems (e.g. itching, rash, acne)	<input type="checkbox"/> History of bed wetting
<input type="checkbox"/> Passed out/dizzy during/after exercise	<input type="checkbox"/> Abnormal menstrual history (if female)	<input type="checkbox"/> Eating disorder
<input type="checkbox"/> Wears glasses, contacts or protective eye wear	<input type="checkbox"/> Orthopedic appliance being brought to camp	<input type="checkbox"/> Emotional difficulties for which professional help was sought

Explanation of checked conditions:

Use this space to provide any additional information about the camper's or staff member's behavior and physical, emotional, or mental health about which the camp should be aware.

Screening Record (For Camp Use Only)

Initial Screening

Date of arrival at camp _____

General condition upon arrival to camp _____

	No	Yes	<i>If yes, please list specifics:</i>
Any recent exposure to communicable disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any recent cold, sore throat, or ear infection?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any recent injuries, such as abrasions, cuts, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any contraindications to camp activity?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Any other information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware? _____

Physical Examination Screening

Throat Check: Result Negative Positive

If positive, list action taken: _____

Lice Check: Result Negative Positive

If positive, list action taken: _____

Medical Review

Regular or PRN medications indicated on Health Record? No Yes *(If yes, list on medication sheet)*

Medications received? No Yes If yes, medications secured in infirmary Yes

List any further information regarding medications: _____

Health Record Review

	No	Yes
Any limitations of activities advised? Place on list to counselor.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergies listed? If yes, circle in red and note on medication sheet..... Place food and other allergies on list to counselor	<input type="checkbox"/>	<input type="checkbox"/>
Medical history completed within past 6 months and signed by parent/guardian.....	<input type="checkbox"/>	<input type="checkbox"/>
Immunization history complete.....	<input type="checkbox"/>	<input type="checkbox"/>
All other sections of the Health Record are complete	<input type="checkbox"/>	<input type="checkbox"/>
Physician's signature present on a physical dated within the past 24 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
Physician's address and phone number listed on physical?	<input type="checkbox"/>	<input type="checkbox"/>
Signature of parent' guardian or staff member giving consent for medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Signature of camper/staff member agreeing to abide by restrictions on activity?	<input type="checkbox"/>	<input type="checkbox"/>

Camp Health Care Personnel Signature

I have screened the above person and reviewed the Health Record on this date.

Signature/Title: _____ Date: _____