Name ______________________________ Cabin ______________________________

# CAMP CHARLES PEARLSTEIN
## Health History and Examination Form for Children and Adults

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate medical care. This form must be filled out ANNUALLY by both parents/guardians of minors or by adult participants themselves (first five pages) AND by licensed medical personnel (last page).

Name ______________________________ Birth Date ____________ Age at Camp ______
*Last* *First* *Middle*

Home Address ______________________________
*Number* *City* *State* *Zip*

Participant's Social Security Number ____________________ Gender: _____Male _____Female

**Custodial Parent/Guardian** ____________________ Home Phone: ____________________

Alternate Phone : ____________________

Home Address ______________________________
*(if different from participant)* *Number* *City* *State* *Zip*

**Second Parent or Emergency Contact** ____________________ Home Phone: ____________________

Alternate Phone : ____________________

Home Address ______________________________
*Number* *City* *State* *Zip*

**Additional Emergency Contact** ____________________ Home Phone: ____________________

Alternate Phone : ____________________

Home Address ______________________________
*Number* *City* *State* *Zip*

**The following boxes MUST be complete for attendance**

This health history is correct as far as I know and completed to the best of my ability. The individual herein named has permission to engage in all camp activities except as noted.

I hereby give Camp Charles Pearlstein permission to provide, seek, and consent to routine medical care, administration of prescribed medications, and emergency treatment for my child/me, as may be necessary, including but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for Camp Charles Pearlstein to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the individual herein named is a minor. Further, it is my intention that representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the individual herein described, as necessary: (a) to provide relevant information to camp representatives related to the individual's ability to participate in camp activities; and (b) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's/my health status .

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Charles Pearlstein to secure and administer treatment, including hospitalization, for the individual named herein. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult participant ______________________________

Printed name ______________________________ Date ____________________

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

Signature of minor or adult participant ______________________________ Date ____________________

Name ____________________________________________ Cabin ______________________________

## Health History

The following information must be filled out by the parent/guardian or adult participant. The intent of this information is to provide Camp Charles Pearlstein health care personnel the background to provide appropriate care. Please keep a copy of this completed form for your records. Any changes to the information contained herein should be provided to Camp Charles Pearlstein health care personnel upon participant's arrival at camp. Please provide complete information so that Camp Charles Pearlstein can be fully aware of your/your child's needs.

**ALLERGIES** (please list all known) — Please describe reaction and management of the reaction

**Medication allergies**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

**Food allergies**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

**Other allergies** (including insect bites/stings, hay fever, animal dander, etc.)

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

**RESTRICTIONS**

The following restrictions apply to this participant:

**Dietary restrictions**

____ Does not eat red meat
____ Does not eat poultry
____ Does not eat seafood
____ Does not eat eggs
____ Does not eat dairy products
____ This participant keeps kosher
____ Other (please describe) ______________________________

**Restrictions to activity** (please describe):

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Name ______________________________ Cabin ______________________________

## Health History, continued

### MEDICATIONS

Please list ALL medications (including over-the-counter or non-prescription drugs) taken **routinely**. Please send/bring enough medication to last the entire stay at camp. All medication must be in its original packaging that identifies the name of the medication, the dosage, the frequency of administration, and the prescribing physician (prescription only).

___ This person takes NO medications on a routine basis

___ This person takes medications as follows (please attach additional pages for additional medications):

| Medication | Dosage | Administration schedule | Reason for taking | Known potential side effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Below is a list of commonly used over-the-counter medications kept at the Camp Charles Pearlstein Mearpa'ah (Infirmary) and administered by the camp nurse (or designee). Brand names are listed, but the generic equivalent may be used at the discretion of the camp nurse (or designee).

**Oral Medications:**
Tylenol
Motrin
Alleve
Robitussin DM
Robitussin CF
Sudafed
Sudafed PE
Halls/Cepacol
Benadryl
Claritin
Dramamine
Tums
Maalox
Immodium A-D
Gas-X

**Topical Medications:**
Aloe
Camphor
Aquaphor
Vaseline
Vanishing Cream
Calamine
Aspercreme
Solarcaine
Benzacaine
Zinc-Ox
Monistat
Tinactin
Menthol
Cortisone
Oragel

If there are medications on the above list that your child **MAY NOT** take, please list them here:

______________________________

______________________________

______________________________

______________________________

Name ______________________________ Cabin ______________________

## Health History, continued

**GENERAL QUESTIONS** (please explain any "yes" answers below)

Has/does the participant (please circle appropriate answer):

1. Had any recent injury, illness, or infectious disease? Y N
2. Have a chronic or recurring illness/condition? Y N
3. Ever been hospitalized? Y N
4. Ever had surgery? Y N
5. Have frequent headaches? Y N
6. Ever had a head injury? Y N
7. Ever been knocked unconscious? Y N
8. Wear corrective eye wear? Y N
9. Ever had frequent ear infections? Y N
10. Ever passed out during or after exercise? Y N
11. Ever been dizzy during or after exercise? Y N
12. Ever had seizures? Y N
13. Ever had chest pain during or after exercise? Y N
14. Ever had high blood pressure? Y N
15. Ever been diagnosed with a heart murmur? Y N
16. Ever had back problems? Y N
17. Ever had problems with joints (knees, ankles)? Y N
18. Have an orthodontic appliance? Y N
19. Have any skin problems (rash, acne)? Y N
20. Have diabetes? Y N
21. Have asthma? Y N
22. Had mononucleosis in the last 12 months? Y N
23. Had problems with diarrhea/constipation? Y N
24. Have problems with sleepwalking? Y N
25. Have an abnormal menstrual cycle? Y N
26. Have a history of bedwetting? Y N
27. Ever had and eating disorder? Y N
28. Ever had emotional or behavioral issues for which professional help was sought? Y N

**Please explain any "yes" answers, noting each question's number:**

______________________________

______________________________

______________________________

______________________________

______________________________

**ILLNESS HISTORY**

This participant has had (please circle any that apply):

MEASLES
CHICKEN POX
GERMAN MEASELS
MUMPS
HEPATITIS A
HEPATITIS B
HEPATITIS C

Date of last TB Mantoux Test:

______________________________

Result of Test: □ Positive □ Negative

**IMMUNIZATION HISTORY**

Please list all immunization dates for the following. Or, you may attach a copy of the current immunization record

| VACCINE | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr |
|---|---|---|---|---|---|
| DTP | | | | | |
| TD (tetanus/diphtheria) | | | | | |
| Tetanus | | | | | |
| Polio | | | | | |
| MMR | | | | | |
| or Measles | | | | | |
| or Mumps | | | | | |
| or Rubella | | | | | |
| Haemophilus influenza B | | | | | |
| Hepatitis B | | | | | |
| Varicella (chicken pox) | | | | | |

Please use the space below to provide any additional information about the participant's health about which the camp should be aware:

______________________________

______________________________

______________________________

Name of family physician ______________________________ Phone ______________

Name of family dentist ______________________________ Phone ______________

Name of family orthodontist ______________________________ Phone ______________

Name ______________________________________________________ Cabin ____________________________________

**INFORMATION FOR PAYMENT OF MEDICAL SERVICES OUTSIDE OF CAMP**

*In the event that treatment by a Physician in Prescott is necessary, **we MUST have this information on file**. The information will be kept in strict confidence and will only be used for medical purposes. Unless impossible, we will inform you prior to using the card.*

**Health insurance information** *(remember: participation at Camp Charles Pearlstein requires coverage by a health insurance policy)*

Insurance plan name ________________________________________________________________________________

Policy # ___________________________________________Group # ________________________________________________

Policy Holder's Name ________________________________ Policy Holder's Date of Birth ________________________________

► **Please attach a photocopy of the participant's health insurance card (front and back) to this form**

**Credit card information**

Card type ______________________________________________________________________________________________

Credit Card Number ____________________________________________ Expiration Date _______________________________

Name as it appears on card: ___________________________________________________________________________

Signature _______________________________________________ Print Name ________________________________________

Name ____________________________________________ Cabin ______________________________

**Health Exam** (to be completed by licensed medical personnel ANNUALLY)

► I examined this individual on (date) ____________.

► BP ______________ Weight ______________ Height ______________

► In my opinion, the above named individual _____ is _____ is not able to participate in an active camp program.

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

**RECOMMENDATIONS AND RESTRICTIONS** (please describe the following)

Treatment to be continued at camp:

Medications to be administered at camp (name, dosage, frequency):

Medically-prescribed dietary restrictions to be followed at camp:

Any limitations and/or restrictions on activities to be enforced at camp:

Any known allergies:

Any additional information you feel will be useful to camp medical personnel:

**SIGNATURE OF LICENSED MEDICAL PERSONNEL** ______________________________________

Printed ____________________________________ Title ____________________________________

Address ________________________________________________________________________

Phone ____________________________________ Date ____________________________________

*For camp use only*

**SCREENING RECORD**

Date Screened ________________________________ Time ________________________________am/pm

Meds Received ________________________________________________________________________

Updates/additions to health history noted (circle one) Yes No None required

Observational notes ____________________________________________________________________

Screened by ________________________________________