

Camper Medical Form

Mail this form to the address below:

The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians. Page 4 to be completed by Physician.

Camp Pelican
15 E. Putnam Ave.-#3330
Greenwich CT 06830

Name: _____ D.O.B. _____ Gender Male Female
Last First

Home Address: _____
Street Address City State Zip

Custodial Parent/Guardian: _____ Cell Phone: _____

Home Address: _____ Home Phone: _____
(if different from above) Street address City State Zip

Business Address: _____ Bus. Phone: _____
Street Address City State Zip

Second parent/guardian/emergency contact: _____ Cell Phone: _____
(please circle one)

Address: _____ Home Phone: _____

Business Address: _____ Bus. Phone: _____
Street Address City State Zip

If above not available in an emergency, notify:

Name: _____ Cell Phone: _____

Relationship: _____ Alt. Phone: _____

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name: _____ Group # _____ Phone: _____

PARENT/GUARDIAN AUTHORIZATION

This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities as noted.

I hereby give permission to the camp to provide routine health care, administer over the counter and/or prescribed medications with doctor's orders only, and seek emergency medical treatment including x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the camp to arrange any related transportation for this camper.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above with the understanding that parents will be notified ASAP. A copy of this form may accompany the camper on trips.

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

Signature of parent/guardian: _____

Printed Name: _____ Date: _____

ALLERGIES List all known

Medication allergies (list)

Describe reaction and management of the reaction

Food allergies (list)

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

ANY MEDICATIONS BEING TAKEN

List ALL medications (including over-the-counter or nonprescription drugs taken routinely).

This person takes **NO** medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: _____

RESTRICTIONS - The following restrictions apply to this individual:

Does not drink milk Does not eat red meat Does not eat fish Does not eat eggs

Does not ice cream Does not eat poultry Does not eat other dairy products

Other (describe) _____

Has/does the participant:	Yes	No	Yes	No
1. Had a recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>		
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>		
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>		
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>		
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>		
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>		
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>		
8. Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>		
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>		
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>		
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>		
15. Been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>		
16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>		
17. Ever had problems with joints (e.g. knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>		
18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>		
19. Have any skin problems (e.g. itching, rash, acne, eczema)?	<input type="checkbox"/>	<input type="checkbox"/>		
20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>		
21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>		
22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>		
23. Had problems with diarrhea/constipation.	<input type="checkbox"/>	<input type="checkbox"/>		
24. If female, have an abnormal menstrual history.	<input type="checkbox"/>	<input type="checkbox"/>		
25. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>		
26. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>		

Please explain any “yes” answers, noting the number of the questions.

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

Which of the following Has the participant had?

Please give all dates of immunization for (or attach immunization form from physician).

<input type="checkbox"/> Measles	Vaccine:	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.
<input type="checkbox"/> Chicken Pox	DTP	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German measles	TD(tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Tetanus	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	Polio	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	MMR	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Measles	_____	_____	_____	_____	_____	_____
	or Mumps	_____	_____	_____	_____	_____	_____
TB Mantoux Test	or Rubella	_____	_____	_____	_____	_____	_____
Date of last test _____	Haemophilus influenza B	_____	_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Hepatitis	_____	_____	_____	_____	_____	_____
	Varicella(chicken pox)	_____	_____	_____	_____	_____	_____

Name of Family Physician _____ Phone _____

Address _____

Name of Family dentist/orthodontist _____ Phone _____

Address _____

Health Care Recommendations by Licensed Health Care Personnel

I examined the individual on _____. (Exam must be within past 12 months of camp attendance)

BP _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program.

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

Recommendations and Restrictions at Camp

Treatment to be continued at camp:

Any medications, including over the counter, to be administered at camp:

- **MUST BE ACCOMPANIED BY A DOCTOR’S WRITTEN ORDER**
- **MUST BE SENT IN THE ORIGINAL PACKAGE/BOTTLE WITH THE PATIENT’S NAME, MEDICATION NAME, DOSAGE AND FREQUENCY OF ADMINISTRATION.**
- **MUST BE ACCOMPANIED BY A SIGNED MEDICAL AUTHORIZATION FORM PROVIDED BY THE CAMP.**

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

Signature of Licensed Medical Personnel _____	
Printed Name: _____	Title _____
Address _____	
Phone _____	Date _____