CAMP MARIASTELLA

Health Information

This form must be received in the Camp Office 2 weeks before child leaves for camp.

Camper's Name _____ Birth Date____/____/____ Age_____
Last *First*

Part I: To be completed by Parent/Guardian:

Check below if the camper has/ has had:

- ☐ Asthma
- ☐ Bed wetting
- ☐ Bleeding/clotting disorder
- ☐ Chronic cough
- ☐ Constipation
- ☐ Convulsions
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Eating disorder
- ☐ Frequent ear infections
- ☐ Frequent colds
- ☐ Frequent headaches
- ☐ Heart defect/disease
- ☐ Hypertension
- ☐ Menstrual problems
- ☐ Mononucleosis
- ☐ Pneumonia
- ☐ Seizures
- ☐ Sleep Walking
- ☐ Stomach upsets

Allergies:

☐ Hay Fever ☐ Penicillin ☐ Insect stings
☐ Plants _____
☐ Drugs _____
☐ Foods _____

Immunization Dates:

_____Tetanus _____Polio
_____Diphtheria _____Rubella:
_____Whooping C. _____Tuberculin

☐ Had emotional problems for which professional help was sought?

Please explain any YES answers: _____
_____

Which of the following has camper had?
☐ Chicken pox ☐ German Measles ☐ Measles ☐ Mumps

Recent exposure to contagious disease? _____ If yes, what disease? _____

Operation or serious injuries (include dates) _____

Chronic or reoccurring illness or condition _____

Other diseases or details we should know _____

MEDICATIONS BEING TAKEN

List ALL medications being taken routinely. Bring enough medication to last the entire time at camp. Put clearly written directions with them. Place them in a plastic bag with name of camper clearly visible and give them to the counselor on the bus.

☐ **This person takes NO medication on a routine basis.**

This person takes medications as follows:
Med #1_____ Dosage_____ Specific times taken each day_____
Reasons for taking: _____
Med #2_____ Dosage_____ Specific times taken each day_____
Reasons for taking _____
Med #3_____ Dosage_____ Specific times taken each day_____
Reasons for taking _____
Attach additional pages for more medications.

Has the camper menstruated?_____ If no, has she had it explained?_____ If yes, is her cycle normal?_____

Glasses?_____ Braces?_____

Any specific activities to be encouraged or limited by physician's advice _____

Dietary modifications _____

Name of family physician_____ Phone_____

Is the participant covered by family medical/hospital insurance? ☐ yes ☐ no

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

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

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp 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 person herein named is a minor. Further, it is my intention that the appropriate 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 disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

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. This completed form may be photocopied for trips out of camp.

In the consideration of the acceptance of said camper, I hereby waive any and all claims for damages against Camp Mariastella and its authorized personnel of any kind or character which may arise out of the attendance of said camp and of its activities and/or arising out of travel to and from said camp.

Photos taken during summer sessions may be used for promotion. I give permission for my child's to be used.

Signature of parent/guardian_____

Printed Name_____ Date:_____

Part II: To be completed by physician

Examination must have been done within 12 months of child leaving for camp. If your child has had a recent exam by a physician, you may attach a copy in lieu of completing Part II below. You must still complete Part I.

Please note in such a way that the Camp Nurse can be aware of necessary precautions and care. Consultation of physician with parent or guardian may be necessary so the physician can complete all information herein.

Part I: Present conditions:

Sinus_____	Abdomen (Hernia, etc.)_____	Throat_____
Blood Pressure_____	Scalp (Pediculosus capitis)_____	Eyes_____
Spine_____	Skin (Ringworm, Eczema, etc.)_____	Ears_____
Thyroid_____	Athlete's Foot_____	Nose_____
Teeth_____	Lungs_____	Other_____

Part II

Height:_____ Weight:_____

Current illness (cold, virus, etc.)? _____ If yes, what illness?_____

Any restrictions:

Any treatment to be continued at camp?_____

Is camper able to participate in the hiking program? ☐ Yes ☐ No

If no, specifically why?_____

Any specific activities to be encouraged or limited by physician's advice?_____

_____

Additional information for health care staff at the Camp:_____

_____

By:_____ Phone ( )_____ Date: _____/_____/_____

(Physician)