

HEALTH HISTORY & PHYSICAL [Part 1]- Camper name: _____ Age: _____

Due: **May 1, Big Shots** **June 1 Little Shots**

Parent/Guardian completes. Primary care physician/pediatrician reviews and initials then completes Part 2.

Check what applies.

Allergies

Hay fever _____
Ivy Poisoning _____
Insect Stings _____
Medicine/drugs _____
Foods _____
Other (specify) _____

Health Conditions

Ear Infections _____
Heart Disease _____
Rheumatic Fever _____
Seizures _____
Behavioral/psych _____
Asthma _____

*If you have checked any of these conditions, explain in the space provided below:

MD Initial _____

Medications Routinely Taken (Other than Insulin)

Medication	Dose	Time(s)	Give at Camp?	
			<u>Yes</u>	<u>No</u>
1. _____	_____	_____	___	___
2. _____	_____	_____	___	___
3. _____	_____	_____	___	___

MD Initial _____

Has your child been hospitalized in the past year (including psychiatric facilities)? YES NO

If yes, please explain: _____

Does your child have any other physical, social or emotional problems other than diabetes? YES NO

If yes, please explain: _____

Has your child ever been on a behavior modification plan or a formal disciplinary plan? YES NO

Is so, were they able to successfully adhere to it? YES NO

Please explain: _____

MD Initial _____

I understand that Diabetes Youth Services may share this health information with other healthcare professionals, including nurses and counselors at Camp Hot Shots, for the health and welfare of our child. Release of information to any other health care providers or persons not listed on this form will occur only with my express permission on behalf of my child who is a minor.

This Health History is complete and accurate. I know of no reason(s), other than as indicated on this form, why my child should not participate in activities except as noted.

Signature of Parent or Guardian

Date

HEALTH HISTORY & PHYSICAL [PART 2] Camper name: _____ Age: _____

To be completed by a licensed Health Care Provider prior to camp to certify that camper is able to participate fully in camp activities during camp dates.

PHYSICAL EXAMINATION

Height _____ Weight _____ Blood Pressure _____ Pupils _____
Eyes _____ Ears _____ Nose _____ Glasses _____
Throat _____ Heart _____ Skin _____ Lungs _____
Posture (spine) _____ Hernia _____ Hx/Rx for STD _____ Musculoskeletal _____
Allergy: Please specify _____
Immunizations are Up to Date? _____

Recommendations and restrictions while in camp:

Dietary restrictions _____
Swimming/Diving _____
Strenuous Activity _____
Other _____

Any specific activities to be encouraged or restricted? _____

Do you know of any physical or emotional issues that might create a problem for this child at camp? _____

Is there anything in this child's health history (physical, mental, emotional) of which we should be aware? _____

I have examined the person herein described and have reviewed the health history. It is my opinion that this person is physically able to engage in all camp activities, except as noted above.

Print Name of Licensed Health Care Provider (MD, DO, NP, PA)

Signature of Licensed Health Care Provider

Address

Date _____

Phone _____