

HEALTH HISTORY - Camper name: _____ Age: _____

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

Check what applies.

Allergies

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

Health Conditions

Ear Infections _____
Heart Disease _____
Rheumatic Fever _____
Seizures _____
Diabetes (see section) _____
Behavioral/psych _____
Asthma _____

*If you have checked any of these conditions or allergies, explain in the space provide below (with the exception of Diabetes):

MD Initial____

Camper has had or has been exposed to any communicable diseases three (3) weeks prior to camp. YES NO

If YES, please explain: _____

MD Initial____

Medications Routinely Taken (Other than Insulin)

Medication	Dose	Time(s)	Give at Camp?	
			Yes	No
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____

OTHER MEDICATIONS (Please check desired doses.)

Mild Pain Relief/Fever (If fever of > 101 Ax parents/guardian will be notified)

Acetaminophen – 10-15 mg/kg q 4 hrs prn **Current weight** _____

Mild Allergic Reaction - rash, nasal congestion (Not to exceed 4 doses in 24-hr period)

___ Benadryl 25 mg po 1 4-6 hrs prn

Severe Anaphylaxis

Ana-Kit Bee Sting Emergency Kit; Contains Epinephrine 1:1000

___ 6 – 12 years - .2ml IM or SQ may repeat x1 after 10 minutes prn

___ >12 years - .3ml IM or SQ may repeat x1 after 10 minutes prn

MD Initial____

I understand that Diabetes Youth Services may share the 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 EXAM - Camper name: _____ Age: _____

Parent/Guardian Name: _____

Health Exam form to be completed by a licensed Health Care Provider prior to Camp.

This examination must be performed within 24 months of arrival at camp. Examination for some other purpose within this time period is acceptable. Examination is to determine fitness to engage in strenuous activity.

IMMUNIZATION HISTORY

Required immunizations must be recorded locally. Please record the date (month and year) of basic immunizations and most recent booster doses or attach a copy of their shot record.

VACCINES	DATE OF BASIC IMMUNIZATION	DATE OF LAST BOOSTER
Diphtheria Pertussis (Whooping Cough) Tetanus (DPT) or	1) _____ 4) 2) _____ 3) _____	
Tetanus Diphtheria (TD) or		
Tetanus		
Oral Polio (Sabin) * TOPV	1) _____ 2) _____ 3) _____	
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)	1) _____ 2) _____	
MMR		
Tuberculin skin test (most recent)	Given _____ Result _____	Chest X-ray _____
Haemophilus influenza b (HIB)		
Hepatitis B	1) _____ 2) _____ 3) _____	

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 _____

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 _____