Health History and Examination Form for Children, Youth and Staff Attending Holmes Camp & Retreat Center

Dates of Camp Attendance _____

Mail this form to the address below by two weeks before the start of your camp session.

Holmes Camp & Retreat Center
60 Denton Lake Rd
Holmes, NY 12531

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health History (page 1 & 2) must be filled out by parents/guardians of minors.

PLEASE HAVE THE HEALTH CARE PROVIDER COMPLETE AND SIGN PAGES 3 & 4.
This information must be updated annually.

Name _____ Birthdate ____/____/____ Age at camp _____
Last First Middle

Home address _____
Street City State Zip

Sex: _____ (for medical purposes) Gender: _____

Custodial parent/guardian _____ Phone: ____-____-_____

Second Parent or guardian or emergency contact _____

If not available in an emergency, notify:

Name _____

Relationship _____ Phone: ____-____-_____

Address _____

Insurance Information

Is the participant covered by family medical/hospital insurance? YES _____ NO _____

If so, indicate carrier or plan name_____Group #_____

Name of Insured _____ Date of Birth of Insured _____

Does this policy include dental insurance? YES _____ NO _____

∗**Photocopy of front and back of health insurance card must be attached to this form.** Note: Your insurance will be the primary coverage. The Holmes Camp & Retreat Center provides coverage for sickness and accidents up to the limits of the policy and will be the secondary coverage. Holmes Camp has a Registered Nurse on staff and on site during our summer camp sessions. Holmes Camp is not a Diabetes Specialty camp and so potential campers with Diabetes will be assessed on a case by case basis. A conversation with the Holmes Camp nurse will be required to make sure that we can provide excellent camping and excellent health care for your child.

HIPPA Privacy Statement: Permission to Release Confidential Information **Parents please complete!**

I give _____ permission to release confidential health information to
(Name of Medical Practice) Holmes Presbyterian Camp and Conference Center regarding this person.

Date:_____ Parent/Guardian Signature_____

Important - These boxes must be complete for attendance

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. 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. I give permission for my child to carry and apply insect repellent with adult supervision. I give permission for my child to carry sunscreen and apply it as necessary during camp sessions at Holmes Presbyterian Camp. I give permission for me/my child to participate in the activities of Holmes Presbyterian Camp and Conference Center, and for his/her picture to be used in publicity.

Signature of parent/guardian or adult camper/staff member _____

Printed name _____ Date_____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.
Signature of minor or adult camper/staffer _____

Camper Name _____

The following information must be filled in by the parent/guardian or adult staff member.

The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to the camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Camper's Health Care Provider Name: _____ Phone: ____-____-____
Address: _____
Camper's Family Dentist/ Orthodontist: _____ Phone: ____-____-____
Address: _____

Emergency Medical Information (check yes or no for each item)

YES ____ NO ____ Allergy to a medicine, food, plant animal or insect
YES ____ NO ____ Do you have an epinephrine pen?
YES ____ NO ____ Any condition which requires special care, medication or diet?
YES ____ NO ____ Asthma
YES ____ NO ____ Contact Lenses
YES ____ NO ____ Seizure Disorder
YES ____ NO ____ Diabetes
YES ____ NO ____ Heart Trouble
YES ____ NO ____ Bleeding Disorder
YES ____ NO ____ Dentures
YES ____ NO ____ Bonded Teeth

Explain any of the above _____

Medical History

Serious Illness YES ____ NO ____ Date _____ Details _____
Serious Injury YES ____ NO ____ Date _____ Details _____

Does your child have frequent: (circle yes or no)
Y / N Eye Infections Y / N Respiratory Infections
Y / N Ear Infections Y / N Urinary Tract Infections
Y / N Throat Infections Y / N Vaginal Infections

Does your child have: (circle yes or no)
Y / N Heart Murmur Y / N Menstrual Problems
Y / N Rheumatic Fever Y / N Hernia
Y / N Stomach/Intestinal Problems Y / N Back or Joint Pains

Explain any of the above _____

Health History

Has this person had Chicken Pox? YES ____ NO ____ If Yes, when? Date _____
Has this person had Mumps? YES ____ NO ____ If Yes, when? Date _____
Has this person been exposed to a contagious disease with the past three weeks? YES __ NO ____ If Yes, when? Date _____
Has this person had lice in the past six months? YES ____ NO ____ If Yes, when? Date _____
If applicable, has this person started menstruation? YES ____ NO ____ Has she been told about menstruation? YES _____ NO ____
Does this person take any medication on a regular basis? YES ____ NO ____ If Yes, when? Date _____

Allergies List all known. Describe reaction and management of the reaction. Medication, food, environment including insect stings, hay fever, etc. _____

_____

Restrictions

The following restrictions apply to this individual.
Dietary
____Vegetarian or Vegan describe _____
____Dairy Allergy ____Milk Product Allergy ____Egg Allergy ____Gluten Free ____Nut Allergy
____Other - If any of the above are checked, please describe so our food service can be prepared _____

_____

_____

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

_____

_____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

_____

_____

Medical Evaluation

Camper Name _____Date of birth___/___/____has had a complete history & physical exam on __/____/____

(American Camp Association accreditation requirements specify exams within 12 months of camp attendance. A new exam is not necessarily required for camp attendance.)

Height:	BMI:	Vision/Type of Screening
Weight:	☐ Normal	With glasses R 20/ L 20/
Blood Pressure:	☐ Abnormal	Without glasses R 20/ L 20/
Pulse:		
HCT/Hgb:	TB: In high risk group? ☐Yes ☐ No	Auditory/Type of Screening
Urinalysis:	TB & other Test Results (sickle Cell, etc)	Right Pass/Fail
Gross Dental:		Left Pass/ Fail
Lead (Date/Result)		

Yes	No		To What:	Date of Onset
☐	☐	Asthma	☐ Mild ☐ Moderate ☐ Severe ☐ Exercise Induced ☐ Unclassified	
☐	☐	Diabetes	☐ Type I ☐ Type II	
☐	☐	Anaphylactic Reaction	☐ Food ☐ Insect ☐ Latex ☐ Other: Explain	
☐	☐	Seizure Disorder	Type:	
☐	☐	Chicken Pox	If yes, when?	
☐	☐	Mumps	If yes, when?	
☐	☐	Other: Please Specify		

DPT/Hib					
DTaP					
DT/Td					
OPV					
IPV					
MMR					
HiB					
Hep B					
Hep A					
Varicellla					
TDap					
PCV					
HPV					
MCV					
Influenza					

Please Record Immunization Dates on Page 3. A copy of a current immunization record is acceptable.

Camper Name _____ Date of Birth: _____

The following Standard "Over the Counter" PRN Medications are available in the Health Center to be administered per package instructions unless otherwise specified by the family physician.

This page must be completed by the Physician. Please cross out any OTC medications not desired for this camper.

Drug Generic equivalents may be used	Route	Dosage	Schedule	Indications	Comments
Diphenhydramine	PO	____MG ____ML	Q_____HRS	Insect Bites, Allergies	
Tums	PO	____MG ____ML	Q_____HRS	Indigestion	
Acetaminophen	PO	____MG ____ML	Q_____HRS	Pain, Fever	
Ibuprofen	PO	____MG ____ML	Q_____HRS	Pain, fever	
Hydrocortisone Cream	Topically	____MG ____ML	Q_____HRS	Insect bites, rash	
Cough Drops	PO	____MG ____ML	Q_____HRS	Cough, sore throat	
Antibiotic Cream	Topically	____MG ____ML	Q_____HRS	Cuts, scrapes	

Non Prescription and Prescription Medications (Please complete with patient's current regimen for both scheduled and prn medications. Use 2nd page if needed) this includes vitamins, inhalers, ear and eye drops. ***Medications must be in the original labeled bottle with directions for administration.***

Drug	Route	Dosage	Schedule and Indications	Comments

I certify that I have on this date examined the above named camper and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this camper to participate in physically strenuous activities.

Signature of Physician _____ Date of Examination _____

Please Print: Physician's Name _____ License # _____
Address_____ Phone # _____