

Glorieta Summer Camps Health Form

Complete and Return to:

THIS FORM MUST BE COMPLETED AND RETURNED BY JUNE 1st:



- Page 1 and Sections 1 & 2 to be completed by parent.
- Sections 3 & 4 to be completed by Licensed Medical Personnel.
- Exception: Section 2 Immunization Record may be completed by Parent or Physician's Office.

Cabin: _____

Session: _____

Year: _____

OFFICE USE ONLY

SESSION ATTENDING: Starter Camp (6/14-6/19) Session 1 (6/21-7/3)

Social Security # _____ Sex _____ Height _____ Weight _____

Name: _____ Age _____ Birth M/D/Y _____ Years at Camp: _____

Parent or Guardian: _____ Phone: (____) _____

Home Address: _____
Street Number City State Zip Code

Sibling(s) Attending Ridgecrest/Crestridge: _____

Mother's Occupation: _____ Work Phone: (____) _____ H Phone: (____) _____

Cell Phone: (____) _____

Father's Occupation: _____ Work Phone: (____) _____ H Phone: (____) _____

Cell Phone: (____) _____

In An Emergency, Please Notify: _____ Relationship: _____ Phone: (____) _____

If **NOT** Available in Emergency, Notify: _____ Relationship: _____ Phone: (____) _____

Name of the Family Physician and/or Health Care Clinic: _____ Phone: (____) _____

Name of Ophthalmologist/Optomestrist: _____ Phone: (____) _____

Date of Last Physical Examination: _____ Name of Physician: _____ Phone (____) _____

Do you carry family medical/hospital insurance? If so, indicate carrier: _____ Policy/Group No. _____

***** PHOTOCOPY OF FRONT AND BACK OF HEALTH INSURANCE CARD AND PRESCRIPTION CARD MUST BE ATTACHED TO THIS FORM. INSURANCE: ACCIDENT INSURANCE is included in the camp fee up to a set limit. Any doctor or druggist bills incurred as a result of illness will be mailed directly to the parents.**

Operations or serious injuries (dates): _____

ALLERGIES:

_____ Asthma _____ Foods: _____

Chronic or recurring illness or medical condition: _____

_____ Hay Fever _____

_____ Poison Ivy _____

Current Prescription Medications: _____

_____ Insect Stings _____ Drugs: _____

_____ Severe (stops breathing) _____

Medical Diet Restrictions: _____

_____ Mild (swollen/rash) _____

_____ Other (notes): _____

PARENT ITINERARY:

If you as a parent or guardian plan to be out of town while your child is at camp, please indicate your complete itinerary below and numbers where you can be reached:

Date	Place	Phone #	

IMPORTANT- MUST BE COMPLETED FOR ATTENDANCE

To my knowledge, this health history is correct and complete. The person herein described has permission to engage in all camp activities except as noted. I 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 treatment, referral, billing, or 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 also give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This form may be photocopied for trips out of camp.

Parent Signature **Date:** _____

I agree to abide by the restrictions placed on my camp activities as noted on this health form.

Camper or Staff Signature **Date:** _____

Name: _____

Complete Page 1 and Sections 1 & 2 BEFORE Seeing Physician: Include emergency information and restrictions / special care that should be observed. Record any injuries, illness, surgery, or significant changes in condition of applicant since last complete exam.

Section 1: Give dates and full details below for any "Yes" Answers.
IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF):

	Yes	No	Year		Yes	No	Year
1. Serious Illness	___	___	___	17. Eyes/Ears	___	___	___
2. Serious Injury	___	___	___	18. Hearing Imp.	___	___	___
3. Deformity	___	___	___	19. Hypertension	___	___	___
4. Surgery	___	___	___	20. Convulsions	___	___	___
5. Skin / Glands	___	___	___	21. Epilepsy	___	___	___
6. Sinusitis	___	___	___	22. Constipation	___	___	___
7. Heart	___	___	___	23. Athlete's Foot	___	___	___
-Murmur	___	___	___	24. Panic Attacks	___	___	___
-Rheumatic Fever	___	___	___	25. Bronchitis	___	___	___
8. Chest / Lungs	___	___	___	26. Fainting	___	___	___
9. Stomach / bowels	___	___	___	27. Depression	___	___	___
10. Appendicitis	___	___	___	28. Sore Throats	___	___	___
11. Kidneys / Urine	___	___	___	29. Bleeding/ Clotting	___	___	___
-Albumin	___	___	___	30. Mono	___	___	___
-Sugar	___	___	___	31. Sprain / break	___	___	___
-Infection	___	___	___	32. Chicken Pox	___	___	___
-Bed-wetting	___	___	___	33. Measles	___	___	___
12. Menstrual Prob.	___	___	___	34. Germ. Measles	___	___	___
13. Hernia	___	___	___	35. Mumps	___	___	___
14. Back/limbs/joint	___	___	___	36. Asthma	___	___	___
15. Sleepwalking	___	___	___	37. Tuberculosis	___	___	___
16. Nervous Cond.	___	___	___	38. Other: explain	___	___	___

39. Are you aware of any current health problems? ___ Yes ___ No
 40. Now under medical care or taking medicine? ___ Yes ___ No
 41. Has there been any surgery, injury, illness, allergy, or change in health status since last physical exam? ___ Yes ___ No
 Details: (Give # & Details or attach separate sheet with info) _____

CONDITION OF EYES: Glasses ___ Contacts ___ NA ___
 What procedures should be taken if broken at camp? _____

CONDITION OF TEETH: Braces ___ Retainer ___ NA ___
 What procedures should be taken if broken at camp? _____

For Girls: Has she Menstruated? ___ If not, has she been informed? ___
 If so, is her menstrual history normal? _____

IMPORTANT: URGENT, FOR THE WELL-BEING OF ENTIRE CAMP, YOU MUST notify the camp if camper is exposed to any communicable disease during the three weeks prior to camp.

Section 2: IMMUNIZATION HISTORY
To be completed by Parent or Physician's Office
 Required immunizations must be determined locally. Please record the date of basic immunizations and most recent boost doses.

Vaccination	Year of Basic Immunization	Date of Recent Booster
DTP	_____	_____
TD (tetanus/diphtheria)	_____	_____
Tetanus	_____	_____
Polio	_____	_____
MMR	_____	_____
Or Measles	_____	_____
Or Mumps	_____	_____
Or Rubella	_____	_____
Haemophilus influenza B (HIB)	_____	_____
Hepatitis B	_____	_____
Varicella (chicken pox)	_____	_____
TB Mantoux Test	Date of last test _____	Pos. ___ Neg. ___

THIS PORTION TO BE FILLED OUT BY LICENSED MEDICAL PERSONNEL

Section 3: HEALTH EXAM

ATTENTION EXAMINER: To attend Glorieta Summer Camps, a health examination within the past 12 months is required. The applicant will be participating in an active and strenuous activity schedule including one or more of the following: athletic participation / competition, horseback riding, water sports, gymnastics, dance, archery, riflery, ropes course, climbing tower, tennis, walking / hiking over rocky terrain, overnight camping and other general camp activities.
 --Please insist applicant furnish complete medical history before exam.
 --Please review immunizations for applicant to insure appropriate immunizations are current. Tetanus booster within last 10 years is required (unless there is a national shortage and booster is unavailable).
 --After completing Section 3, summarize any restrictions and/or recommendations in Section 4, below, **AND ATTACH ANY ADDITIONAL INFORMATION.**

Height ___ Weight ___ Blood Pressure ___ / ___ Pulse ___

Hearing: ___ Normal ___ Abnormal

Vision: ___ Normal ___ Glasses ___ Contacts ___

Check box if normal, circle if abnormal, and give details below:

- | | |
|--|---|
| <input type="checkbox"/> Growth development | <input type="checkbox"/> Skin, glands, hair |
| <input type="checkbox"/> Head, neck, thyroid | <input type="checkbox"/> Ears |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Nose |
| <input type="checkbox"/> Teeth, tonsils | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Abdomen, hernia |
| <input type="checkbox"/> Skeletomuscular | <input type="checkbox"/> Neuropsychiatric |
| <input type="checkbox"/> Other (specify) _____ | |
| <input type="checkbox"/> Comments _____ | |

Participant is under the care of a physician for following conditions:

Condition	Current Medication	To be continued at camp
_____	_____	Specify dose or treatment _____
_____	_____	_____

Any condition that may require special care, medication, or diet:

___ Asthma ___ Convulsions / Epilepsy ___ Heart Trouble ___ Contacts
 ___ Diabetes ___ Fainting ___ Dentures ___ Bleeding Disorders
 ___ Concussion / Loss of Consciousness ___ ADD / ADHD

Circle Allergies to: drugs, foods, plants, animals, insects, chemicals

Specify: _____

Indicate treatment: _____

Explain or **ATTACH** additional information _____

Section 4: EXAMINER'S EVALUATION AND ADVICE:

Date Examined: _____
 I have examined camp applicant within the past year. In my opinion the applicant's condition ___ does ___ does not permit participation in an active camp program.
 Specific restrictions/Recommendations: (explain other limitations or restrictions) _____

ADDITIONAL INFORMATION IS ATTACHED

Licensed Examiner's Signature: _____

Address: _____

Phone: _____

Date of Form Completion _____ *By _____

*Initial if completed by nurse or nurse practitioner

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