



# HEALTH & MEDICAL RECORD 2011

### Directions for Parents:

1. Complete pages 1 -3
2. Have a doctor review pages 2 & 3, and have the doctor sign the form on page 3.  
Return this form to camp by:  
**April 1, 2011**

Child's Name \_\_\_\_\_ Birth date \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_\_\_ **Height\*** \_\_\_\_\_ **Weight\*** \_\_\_\_\_

Name of Siblings also at Camp Harmony \_\_\_\_\_

Father's Full Name \_\_\_\_\_ Mother's Full Name \_\_\_\_\_

Full Address \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Work # (Dad) \_\_\_\_\_ Work # (Mom) \_\_\_\_\_

Cell # (Dad) \_\_\_\_\_ Cell # (Mom) \_\_\_\_\_

**\*NOTE: Accurate current height and weight info is mandatory for campers under 8 years of age for the assignment of the proper car/booster seat.**

### ACCESS CODE

Please provide a password or numerical code, which will be asked of you or anyone you designate to pick up or visit your child.

\_\_\_\_\_ *If you leave this blank, we will assign one.*

### EMERGENCY CONTACT INFORMATION

Please provide names of people whom you authorize to pick up your child, and whom we can contact in the case of an emergency when you cannot be reached. Please advise them that they have been listed, give them your access code, and inform them that they MUST have the access code AND photo identification when they arrive at camp. We will NOT release a child to ANYONE without the proper information, identification or access code.

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Full Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Full Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

### HEALTH CARE PROVIDERS

Name of primary doctor(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of dentist(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### MEDICAL INSURANCE INFORMATION

This camper is covered by family medical/hospital insurance  Yes  No

**Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.**

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Subscriber \_\_\_\_\_ Insurance Company Phone Number (\_\_\_\_) \_\_\_\_\_

Camper Name _____
Date of Birth _____

## IMMUNIZATION RECORD

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster (Dt) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenza type B						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) <input type="checkbox"/> Had chicken pox on _____						
Meningococcal meningitis (MCV4)						
H1N1						

Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
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## HEALTH HISTORY

Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

- |   |                              |                             |   |                              |                             |
|---|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| 1. Ever been hospitalized? .....                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 11. Had fainting or dizziness? .....                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Ever had surgery? .....                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? .....          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? .....        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?.... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Had a recent infectious disease? .....         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Had a recent injury? .....                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 15. Been treated for head lice this year ? .....              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 16. Ever had back/joint problems?.....                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have diabetes? .....                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 17. Traveled outside the country in the past 9 months?.....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Had seizures? .....                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?.....            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Had headaches? .....                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 19. Have any skin problems?.....                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Wear glasses,contacts,or protective eyewear?* | <input type="checkbox"/> Yes | <input type="checkbox"/> No |   |                              |                             |

\*Sports goggles are required for all sports activities.

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

## MENTAL, EMOTIONAL, AND SOCIAL HEALTH

Check "Yes" or "No" for each statement.

Has the camper:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect the camper's life?.....                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Camper Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_

## MEDICATIONS

- Does this camper have an epi-pen?  Yes  No  
 This camper will not take any daily medications while attending camp.  
 This camper will take the following daily medication(s) while at camp:

**Please review camp instructions about required packaging/containers.**

Name of medication	Date started	Reason for taking it	Amount or dose given	How it is given	Time to be given

## NON-FOOD ALLERGIES

- This camper has no known non-food allergies.  
 This camper is allergic to:  
 Food  Medicine  Environment (bee sting, hay fever, etc.)  Other

Please list all non-food allergies here: \_\_\_\_\_

## FOOD ALLERGIES & DIET

- This camper has no food allergies.  
 This camper eats a vegetarian diet.  
 This camper has the following dietary restrictions (include any specific items, the nature and reason for the restrictions, and any other information that would assist us in making sure that your child receives adequate nutrition but remains healthy. Please attach additional doctor records or detailed descriptions of precautions, as well as remedies if necessary.

Item(s)	Reason for Restriction – Nature of Allergy – Possible Reaction

## AUTHORIZATIONS/RESTRICTIONS

- I give permission for my child's name, address and phone to be given to other campers in his/her group or on his/her van.  
 I give permission for my child to be named in the Schmata, our camp newsletter, which is only distributed to registered families.  
 I give permission for my child to appear in promotional materials and/or videos (not identified by name).  
 I have read the parent handbook, and my child is approved for all activities as listed in the handbook, except as noted below:

In the case of In the case of an **EMERGENCY**, and **only in the event that I cannot be reached**, I hereby authorize CAMP HARMONY to act as my agent to secure any emergency treatment considered necessary for my child.

\_\_\_\_\_  
 Signature of Parent/Guardian Date

## TO THE PHYSICIAN:

Date of last physical (must be after June 2010): \_\_\_\_\_  
 Do you feel that the camper will require limitations or restrictions to activity while at camp?  No  Yes  
 If yes, what do you recommend? (attach additional information as necessary)

**"I have reviewed this form, and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)"**

Name of licensed provider (please print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Address \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_