

CAMPER HEALTH HISTORY FORM 2010

Applicant's Name: _____

Applicant's doctor name _____ Office Phone _____ Fax: _____

Applicant's approximate height _____ Approximate weight _____

IMMUZINATION RECORD

Give the *most recent date for all* of the following:

Last DPTP:

Diphtheria _____ Tetanus _____ Polio _____ Pertussis _____

MMR _____ TB Skin Test: Positive _____ Negative _____

If positive, date of last X Ray and result _____

Hepatitis B series _____

ALLERGY RECORD

List any known medication allergies: _____

List any other known allergies (if allergic to bees, describe reactions): _____

DISEASE/ILLNESS RECORD

Place a check mark (✓) next to the disease or illness that the applicant has had a history of.

Circle check mark (✓) of any that are current problem

- | | | | |
|---------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> High Blood Pressured | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Athlete's foot | <input type="checkbox"/> Fainting | Average Reading?: | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Kidney/Bladder Infections | <input type="checkbox"/> Sinus infections |
| <input type="checkbox"/> Chickenpox: | <input type="checkbox"/> Frequent Sores Throats | <input type="checkbox"/> Measles | <input type="checkbox"/> Stomach Upsets |
| <input type="checkbox"/> Mild <input type="checkbox"/> Severe | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis/Hepatitis Carrier | <input type="checkbox"/> Pertussis (whooping cough) | |

MISCELLANEOUS HEALTH QUESTIONS

RECENT SERIOUS ILLNESS, INJURY, HOSPITALIZATION or SURGERY?

If YES, please explain

SEIZURE HISTORY

yes no If yes, what type? _____ Controlled? _____

Describe seizure activity – how often, duration, observed behaviours, what happens after seizure

PHYSICAL THERAPY – NOTE: Camp staff can only provide simple range of motion and/or stretching exercises (no more than two times a day) for campers who have these as a part of their regular, daily routine. Please check all the apply:

- | | | | |
|------------------------------------------------|-----------------------------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Not necessary at camp | <input type="checkbox"/> Not on days camper goes swimming | <input type="checkbox"/> Once a day | <input type="checkbox"/> Twice a day |
| <input type="checkbox"/> Range of motion | <input type="checkbox"/> Arms | <input type="checkbox"/> Legs | <input type="checkbox"/> Stretching |
| | <input type="checkbox"/> Arms | <input type="checkbox"/> Legs | |

FOR FEMALE APPLICANT

Has she menstruated? yes no If no, has she been told about menstruation? yes no

Does she usually have cramps? yes no What usually helps her cramps? _____

IMPORTANT INFORMATION – PLEASE READ CAREFULLY

PRESCRIPTION MEDICATIONS: Only those prescribed by camper’s doctor or authorized by the camp doctor will be administered at camp. **BE CERTAIN THAT DOSAGES LISTED BELOW MATCH EXACTLY THE INFORMATION ON THE PRESCRIPTION BOTTLE OR BE SURE TO PROVIDE CHANGES IN WRITING FROM CAMPER’S DOCTOR.**

OVER-THE-COUNTER MEDICATIONS (vitamins, cold remedies, pain relievers, etc.): These will be given by the camp nurse (s) according to the Standing Orders signed by the camp doctor. Medications specified in the Standing Orders are stocked by Handi*Camp health care personnel. Other over-the-counter products can be brought to camp, but can ONLY be administered according to written instructions provided by applicant’s parent/guardian.

* Please send more than enough of needed medication (prescription or over-the-counter) to camp for applicant. **SEND ALL MEDICATIONS (including vitamins and other over-the-counter items) IN ORIGINAL BOTTLES/CONTAINERS – do not transfer them to another containers!**

MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER) CURRENTLY BEING TAKE

Name of medication	Dosage (mg) & number	Time taken	Name of medication	Dosage (mg) & number	Time taken

HEALTH INSURANCE INFORMATION AND RELEASE STATEMENTS

Each camper is covered by a basic camp insurance policy for accidents and illnesses occurring at camp. However, if any medical situation arises during camp, which involves a camper’s pre-existing disability condition, our insurance carrier will not provide coverage. (For example, a camper may have a string of recurring seizures that needs monitoring at the local emergency room. If there was no direct cause of the condition related to the camper’s participation at camp, our insurance carrier would not cover the hospitalization costs.) For this reason, we are asking for information related to any health insurance coverage besides OHIP.

If YES, name of insurance _____ Police or ID number _____

IMPORTANT NOTE: PLEASE BRING CAMPER OHIP CARD TO CAMP. We will keep each card on file during the camp session and return it at the end of the week.

Please carefully read each release statement below. Then sign and date each one before returning application to the camp office. Applicant will not be allow to attend a camp session unless the Medical Release and the Liability Release statements are properly signed by a parent or legal guardian. The Photo release is not required for acceptance, but having permission to uses photos is requested and appreciated.

MEDICAL RELEASE STATEMENT

In the case of medical or surgical emergency, I hereby give permission to the physician selected by Handi*Camp to hospitalize, secure power treatment for, and to order injection, anaesthesia, or surgery for my child. I also give permission for the release of medical information for the completion of insurance forms.

Signature _____ Relation to Applicant _____
 Applicant’s Full Name _____ Date _____

NOTE: Is applicant a foster child? If so, please provide name and phone number of applicant’s case worker in the event we need verbal permission to provide medical treatment.

Name of case worker _____ Office Ph () _____ After-hours Ph () _____

LIABILITY RELEASE TREATMENT

The undersigned, intending to be bound hereby, realizing that it is Handi*Camp’s desire to give to each camper a safe and beneficial stay, releases HANDI*CAMP, HANDI*VANGELISM CANADA, and/or BCM INTERNATIONAL (CANADA) INC. and Mill Stream Bible Retreat Centre (Crusaders Bible Camp), and all individuals associated therewith from any and all liability for any injury or damage which may be sustained by the undersigned and/or child of the undersigned or property of the same, at or in transit to or from any camp conducted by or under their auspices.

Signature _____ Date _____

PHOTO RELEASE STATEMENT

I give permission for any photographs or slide to be reproduced in brochures, newsletters or other publicity for the Handi*Camp program, or used for training purposes.

Signature _____ Date _____