Camp Arrowhead
FOR BOYS

MEDICAL FORM – 2008 SEASON

Camper Name: ________________________, ________________________ Birth Date: ___________
(Last) (First)

Home Phone: _____ - _____ - ________

Custodial Parents

	Mother	Father
Full Name		
Cell Phone		
Work Phone		
Other Phone		

Summer Residence (If applicable)

Dates Away: From ___________ through ____________ Summer Phone: ___________________

Emergency Information

Name	Relationship to Camper	Phone

In case of emergency, we will contact the above if we cannot reach you.

Family Health Care Providers

	Name	Phone
Primary Physician/Pediatrician		
Dentist		
Orthodontist (if applicable)		
Mental Health Provider		

Health Insurance

Insurance Carrier: ____

Carrier Address: _____________________________ Carrier City, State, Zip: ____________________________

Policy Number: _____________________________ Group Number: ___________________________________

Name of Insured: _____________________________ Relationship to Camper: ____________________________

Insured's Social Security or Insurance ID Number: ____

Prescription Plan Carrier: ________________________________ Prescription Plan Number: ________________

NOTE: If you have more than one child at camp this season, this page need only be completed once.

Camper Name: ____

Health History

Indicate the following by entering an approximate date of last occurrence. Leave blank if not applicable.

Disease	**Date**	**Disease**	**Date**
Chicken Pox:	____________	Asthma:	____________
Measles:	____________	Hepatitis A:	____________
German Measles:	____________	Hepatitis B:	____________
Mumps:	____________	Hepatitis C:	____________

Allergies (Non-Dietary)

- ❑ Ivy Poisonings, etc.
- ❑ Insect Stings
- ❑ Penicillin
- ❑ Other (Specify) ____

Dietary Allergies

❑ Peanut	❑ Shell Fish	❑ Citrus	❑ Wheat
❑ Tree Nuts	❑ Flat Fish	❑ Mustard	❑ Whey

Other Dietary Allergies or Comments. Include description of critical allergic reactions.

____

____

____

Operations or Serious Injuries (with Dates)

____

____

Chronic or Recurring Illnesses:

____

____

____

Other Diseases or Additional Information About the Above:

____

Camper Name: ____-

Immunization

Please record the date (month and 4-digit year) of basic immunizations and the most recent booster doses.

DTP					
TD (Tetanus/Diphtheria)					
Tetanus					
Polio					
Haemophilus, Influenza B					
Hepatitis B					
Varicella (Chicken Pox)					
MMR					
or Measles					
or Mumps					
or Rubella					

TB Maritoux Test	Date:	❑ Test was positive

Has this person ever tested positive for HIV: ❑ Yes ❑ No

Mental/Emotional Health

Please check any that apply and explain below:

❑ Diagnosis of Attention Deficit Disorder (ADD or AD/HD)
❑ Diagnosis of depression, OCD, panic/anxiety disorder
❑ Significant learning or processing challenge (disability)
❑ Currently seen by professional for mental/emotional health concerns
❑ Treated with medications for mental/emotional problem
❑ Other emotional health concern)

Comments: ____

____

____

If any of the above are checked, please have the mental health professional send a written statement to the camp, describing:

a) The condition and treatment plan, including any medications
b) Any behavior at camp that indicates to the staff that the applicant needs a professional referral
c) A recommendation for participation in our camp program

If medication for any of the above has been prescribed, also provide:

d) Certification that the applicant has been taking the same medication at the same dose for 3 months prior to the start of camp
e) If (d) is not true, a detailed explanation for the change in medication.

Camper Name: ____-

Medications

Send enough medication to last while your child is at camp. Keep it in the original packaging. If a prescription, the label should include the drug, dosage, time(s) of delivery and the physician's name.

If the applicant is to take medications routinely at camp, including over-the-counter or other non-prescription drugs, please enter these medications below.

Medication (or common name) **Dosage** **Delivery**

1. ______________________ ____________ ❑ Breakfast ❑ Lunch ❑ Dinner ❑ Bedtime

Physician: ______________________________________ ❑ Taken regularly ❑ As needed

Physician's Phone: _______________________________ ❑ While at camp ❑ Until ___ / ___

2. ______________________ ____________ ❑ Breakfast ❑ Lunch ❑ Dinner ❑ Bedtime

Physician: ______________________________________ ❑ Taken regularly ❑ As needed

Physician's Phone: _______________________________ ❑ While at camp ❑ Until ___ / ___

3. ______________________ ____________ ❑ Breakfast ❑ Lunch ❑ Dinner ❑ Bedtime

Physician: ______________________________________ ❑ Taken regularly ❑ As needed

Physician's Phone: _______________________________ ❑ While at camp ❑ Until ___ / ___

4. ______________________ ____________ ❑ Breakfast ❑ Lunch ❑ Dinner ❑ Bedtime

Physician: ______________________________________ ❑ Taken regularly ❑ As needed

Physician's Phone: _______________________________ ❑ While at camp ❑ Until ___ / ___

Special Medication Instructions:

____

____

____

____

Camper Name: ____-

Medical Insurance and Prescription Cards

Please photocopy both sides of your family's insurance and prescription card and attach here. The prescription card will be used if your child requires prescription medications this summer.

MAKE SURE COPIES ARE LEGIBLE

Medical Insurance Card (Front)

Medical Insurance Card (Back)

Prescription Card (Front)

Prescription Card (Back)

Note: If you have more than one child at camp, you only need to supply this page one time.

Please notify the camp if this person is exposed to any communicable disease during the three weeks prior to camp attendance.

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Physician's Examination

Patient: ________________________, ___________________
(Last) (First)

Address: ____

City/State/Zip ____

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activity.

Codes: V- Satisfactory X – Not Satisfactory O – Not examined

Height: _________ Weight: _______ Heart: ___________ BP: ________________

Hct/Hgb Test: ___________________ Urinalysis: ___________________________

Eyes: ________ Ears: ____________ Nose: _______ Throat: __________ Lungs: _______

Glasses: ________ Extremites: _______ Genitalia: _______ Abdomen: _______ Hernia: _______

Skin: ___________ Posture: __________

Allergy (Please specify): ____

General Appraisal: ____

Is this person up to date on all routine childhood immunizations? ❑ Yes ❑ No

Date of last tetanus shot: __________________

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

Special Diet: ____

Current Medications: ____

Swimming/Diving: ____

Strenuous Activity: ____

Other: ____

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 camp activities, except as noted above.

____ ____________________________________-
(Examining Physician) (Telephone)

Date ________________________