Living Waters Health History and Examination Form

Event Name & #	Camp Use Only

Please fill-out completely, being sure to sign where indicated and return to camp within two weeks of the desired event. **Return form to: Living Waters, 300 Camp Living Water Rd., Schellsburg, PA 15559**.

Camper Information:

Last name________________________________ First ______________________ MI______Birthdate____________ Age at camp________

Street Address____ City___________________________ St_________ Zip__________

Home Phone_________________________________ Most Recent Grade Completed ___________ Gender:

Parent/Guardian Information: Name____ **Email**______________________________

Street Address (if different from above)____________________________________ City__________________ St_________ Zip__________

Relationship to Camper____________________________ Cell Phone____________________________ Home Phone_________________

Second Contact or Second Parent: Name____

Street Address____ City____________________________ St________ Zip__________

Relationship to camper:____________________________ Cell phone__________________________ Home phone_________________

Third contact number: Name____ Relationship to camper_______________________

Home phone____ Cell Phone____

IN CASE OF EMERGENCY CONTACT (1) ________________________ (2) ________________________ (3) ________________________

Insurance Information: Is the participant covered by family medical/hospital insurance?

If yes, indicate carrier or plan name____ Group #____________________________________

Carrier address____ Insurance ID Number__________________________

Name of insured____ Relationship to camper________________________

Family Physician____ Phone number________________________________

Family Dentist/Orthodontist____Phone number______________________________

ALLERGIES – List all known

Medications Allergies (list) | Describe reaction and management of the reaction

____ ____

____ ____

Food Allergies (list)

____ ____

____ ____

Other (list) – these include insects, hay fever, asthma, animal dander, etc…..

____ ____

____ ____

Provide other information camp personnel should know as care is provided for the above-mentioned participant:

____

____

Food Restrictions:____

____

____

Activity Restrictions:

Explain any restrictions to camp activities: (What cannot be done, what adaptations or limitations are necessary)

____

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Swimming Skill: What type of swimmer is your child?

General Questions:

Has/ Does the participant:

1. Had a recent injury, illness or infection?
2. Have a chronic or recurring illness/condition?
3. Have frequent headaches?
4. Wear glasses, contact, protective eyewear?
5. Ever had seizures?
6. Ever had high blood pressure?
7. Ever had problems with joints (knees, ankles)?
8. Have problems with sleepwalking?
9. Have problems with bedwetting?
10. Ever had an eating disorder?
11. Ever had emotional difficulties for which professional help was sought?

Please explain any questions answered "yes": ____

____

Recent Illness: Please describe any recent illness and when the camper had them: ______________________________

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Immunizations: Participants meets all existing state school attendance immunization requirements:

Tetanus: Participant's last tetanus inoculation was on: ______________________________________(Month/Year)

PRESENT MEDICATIONS

In the space provided below (and on a separate sheet of paper if necessary), please list ALL forms of medication taken by the camper, including prescription and non-prescription (over-the-counter) drugs. Please place these medications in a zip lock bag with the camper's name clearly marked on the bag. All medications (prescription and non-prescription) must be in the original packaging or prescription bottles with dosage instructions and prescribing physician information.

Name of Medication	Dosage	Specific times taken each day or Taken as needed
# 1 ______________________	__________	______________________________
Reason for Taking______________________		
# 2 ______________________	__________	______________________________
Reason for Taking______________________		
# 3 ______________________	__________	______________________________
Reason for Taking______________________		
# 4 ______________________	__________	______________________________
Reason for Taking______________________		

Please list medications that are taken during the school year that the camper does not take during the summer:

____

☐ Over the counter medications may be administered as needed

____
Signature required authorizing Over the Counter Med Use

Parent/Care Provider Authorization:

All information on this Health Examination Form is correct and complete to the best of my knowledge. By affixing my signature below, I hereby grant permission for the camper/participant to: (1) engage in all camp activities, unless otherwise noted (2) receive routine health care, administer medications and seek emergency medical treatment including x-rays or tests, and (3) provide any necessary transportation. I also agree to release any records necessary for medical treatment or insurance purposes. In the event, I, or one of the alternate people on the first page cannot be reached in an emergency; I hereby authorize the camp physician, camp nurse or executive director to secure and administer treatment, including hospitalization.

____
Signature of Parent/Care Provider or Adult Camper   Date

____
Please print above name

I understand and agree to accept any restrictions placed on my participation in camp activities.

____
Signature of Camper   Date

CHECK-IN INFORMATION – CAMP STAFF ONLY

CHECK-IN DATE__________________

TIME ______________________

REVISIONS/EXPANSIONS TO HEALTH INFORMATION

yes   no   none needed

____
CHECKED IN BY

FOR USE BY CAMP STAFF ONLY - Medical Treatment Information

Camper's Name ____ Event ____________________

Date ______________________________ Nurse's Signature ______________________________

MEALS - Breakfast 8:00 **Lunch 12:15** **Dinner 5:30** **Night 8:00 - 9:00**

		Sun				Mon				Tue				Wed				Thur				Fri				Sat			
	Date																												
Medication & Dosage	Rx Time	B	L	D	N	B	L	D	N	B	L	D	N	B	L	D	N	B	L	D	N	B	L	D	N	B	L	D	N

Camper Treatments

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