Event Name & #	Camp Use Only

Living Waters Health History and Examination Form

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: Male Female

Parent/Guardian Information: Name____ Phone______________________________

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____

<u>IN CASE OF EMERGENCY CONTACT</u> (1) _________________________ (2) _________________________ (3) _________________________

Insurance Information: Is the participant covered by family medical/hospital insurance? Yes No

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)

____

____

____

Swimming Skill: What type of swimmer is your child? (circle one) Weak Intermediate Strong

General Questions:

Has/ Does the participant:

1. Had a recent injury, illness or infection? Yes No
2. Have a chronic or recurring illness/condition? Yes No
3. Have frequent headaches? Yes No
4. Wear glasses, contact, protective eyewear? Yes No
5. Ever had seizures? Yes No
6. Ever had high blood pressure? Yes No
7. Ever had problems with joints (knees, ankles)? Yes No
8. Have problems with sleepwalking? Yes No
9. Have problems with bedwetting? Yes No
10. Ever had an eating disorder? Yes No
11. Ever had emotional difficulties for which professional help was sought? Yes No

Please explain any questions answered "yes": ____

____

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

____

Immunizations: Participants meets all existing state school attendance immunization requirements: Yes No

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______________________________		

Health Care Recommendation by Licensed Medical Professional

To avoid additional expenses, this form may be completed by a Licensed Medical Professional based on an exam performed within 24 months of camp attendance. A NEW EXAM is not necessary for camp attendance.

I examined this individual on: ____________________

BP____________________ Weight ____________________ Height ____________________

This applicant IS / IS NOT able to participate in an active camp program.

This applicant is under the care of a physician for the following conditions:

____

____

____

Recommendations & Restrictions at Camp – Please list any that apply:

1. Treatment to be continued: ____________________
2. Medications to be administered at camp: ____________________
3. Medically prescribed meal plan or dietary restrictions:____________________
4. Known Allergies: ____________________
5. Description of limitations or restrictions on activities: ____________________
6. Additional information for camp health care staff: ____________________

____

Signature of Licensed Medical Professional Title

____

Office Telephone Number Date

- ☐ This person takes no medication on a regular basis
- ☐ Over the counter medications may be administered as needed

____

Signature required authorizing OTC 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, (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 physician selected by the camp 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

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

CHECK-IN INFORMATION – CAMP STAFF ONLY

CHECK-IN DATE_________________ REVISIONS/EXPANSIONS TO HEALTH INFORMATION

TIME _____________________ yes no none needed

____

CHECKED IN BY

	Date	Sun				Mon				Tue				Wed				Thur				Fri				Sat			
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