

CAMP HEALTH HISTORY

Required for all persons in attendance at camp. Accurate information is important for each person's health and safety. A medical exam by a physician is recommended but not required.



Please return to:
 Hopewell Camp & Conference Center
 24 CR 231
 Oxford, MS 38655

Name _____ Social Security # _____
 Parent or Guardian _____ Birth Date ____/____/____ Age ____ Sex ____
 Home Address _____ Phone _____
 E-mail Address _____ Cell #(M:) _____ (F:) _____
 Mother's Work Address _____ Phone _____
 Father's Work Address _____ Phone _____
 Second Emergency Contact _____ Phone _____
 Address _____
 Third Emergency Contact _____
 Address _____

HEALTH HISTORY: Give approximate dates for each of the following, if applicable.

Ear Infections _____	Psychiatric Treatment _____	Allergies (√)
Heart Defect/Disease _____	Mononucleosis _____	Hay Fever _____
Seizures _____	Give Dates Disease/Immunization	Poison Ivy _____
Diabetes _____	Chicken Pox _____ / _____	Insect Stings _____
Bleeding Disorders _____	Measles _____ / _____	Penicillin _____
Hypertension _____	German Measles _____ / _____	Other Drugs _____
HIV (Optional) _____	Mumps _____ / _____	Asthma _____

If Camper has ever required psychiatric counseling or hospitalization, please explain. _____

Please list any operations or serious injuries with dates. _____
 Please identify any disability or chronic or recurring illness. _____
 List all current medications. _____

• **All medications must be properly identified and sent with instructions. Prescriptions must be in their original container with the prescription number, instructions and the Doctor's name.**
 (Medications will be dispensed as prescribed, by the camp Health Director.)

Activities to be encouraged: _____
 Dietary restrictions or modifications: _____
 Other details on anything above: _____
 Dentist/Orthodontist: _____ Phone() _____
 Family Physician: _____ Phone() _____
 Date of last physical examination: _____ Physician: _____
 Medical Insurance Carrier: _____ Policy or Group # _____
 Insurance Address: _____
 Suggestions or other health related information to help us serve your child better: _____

(For Female): Has this person menstruated? _____ If not, has she been told about it? _____
 If so, is her menstrual history normal? _____ Special considerations: _____

OTHER NOTES OR SUGGESTIONS:

For Office Use Only:
 Camper's Name

Cabin

Year

IMMUNIZATION HISTORY

This Data is required for admittance. Please record the date of immunization and most recent booster.

VACCINES	YEAR OF BASIC IMMUNIZATION	YEAR OF LAST BOOSTER
Diphtheria, Pertussis, Tetanus: DPT or		
Tetanus, Diphtheria: TD or		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard, red measles, Rubeola)		
Rubella (German measles, 3-day measles)		
Mumps		
Other _____		
Tuberculin test given _____ (most recent)		

This health history is correct so far as I know, and the person listed above has permission to engage in all camp activities except as noted. I hereby give permission to the camp: 1. To provide ongoing health care. 2. To select medical personnel and to order X-rays or routine test or treatment for the person listed above. 3. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for the person named above. This form may be photocopied for use out of camp. There are no undisclosed conditions that might affect this person's participation in the camp program.

Signature of parent or guardian of child OR adult camper _____

Witness _____ Date _____

I understand and agree to follow doctor's orders and abide by the restrictions placed on my camp activities.

Signature of camper _____ Date _____

Health screening by camp Health Director: Date _____ Time _____

Temperature? _____ Sore throat? _____ Congestion? _____

Infections? _____ Redness in eyes? _____ Skin rashes evident? _____

Evidence of injury? _____ HL? _____

Any cuts or scrapes that will need care during camp? _____

Has camper been exposed to anyone with a contagious disease in the past week? _____

If yes, explain: _____

Is the camper under care of a physician for any condition? _____

If yes, explain: _____

Explain any allergies: _____

Explain any dietary needs: _____

Is the camper taking any medications? _____ If so, have all medications been turned over to the Health Director? Make sure all instructions are clear.

Medications:	Condition being treated	Dosage	Times to be administered
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____