

**CCCR, Inc. - Aldersgate Center**

**Health History and Examination Form for Children and Youth Attending Camp**

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in providing appropriate care.

Camp Event(s): \_\_\_\_\_ Corresponding Date(s): \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Day Phone \_\_\_\_\_

Evening Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Second Parent/Guardian/Emergency Contact \_\_\_\_\_ Day Phone \_\_\_\_\_

Evening Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If not available in an emergency, please notify:

Name \_\_\_\_\_ Day Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Evening Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

<b>Health History</b> <i>(Check, Give appropriate dates.)</i>
_____ Frequent Ear Infections
_____ Heart Defect/Disease
_____ Convulsions
_____ Diabetes
_____ Blood/Clotting Disorders
_____ Hypertension
_____ Mononucleosis
<b>Diseases</b>
_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps
<b>Allergies (Dates Not Needed)</b>
_____ Hay Fever
_____ Ivy Poisoning, etc.
_____ Insect Stings
_____ Penicillin
_____ Other Drugs
_____ Asthma
_____ Other (Specify)
_____
_____

Has this person ever required any psychiatric counseling or hospitalization? \_\_\_\_\_

Explain \_\_\_\_\_

Operations or serious injuries (dates) \_\_\_\_\_

Chronic or recurring illness or medical condition \_\_\_\_\_

Dietary modifications \_\_\_\_\_

Current medications (send with instructions) \_\_\_\_\_

Other diseases or details of above \_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Do you carry family medical/hospital insurance?  Yes  No

If so, indicate: Carrier \_\_\_\_\_ Policy or Group# \_\_\_\_\_

Suggestions on health related information for camp personnel \_\_\_\_\_

For Female

Has this person menstruated? \_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_

If so, is her menstrual history normal? \_\_\_\_\_ Special Consideration \_\_\_\_\_

This health history is correct as far as I know and the person herein described is able to engage in all prescribed activities except as noted. I hereby give authorization to The Rev. Tanya L. Bennett and Mark Miller, Music Camp directors at Liebenzell Center (FOR MUSIC CAMP ONLY) and to Aldersgate Center (FOR OTHER CAMP EVENTS) to provide ongoing health care to my son/daughter and give permission to the medical personnel selected by them to order X-rays, routine tests, treatment and necessary transportation for my child. I hereby give permission to the physician selected by The Rev. Tanya L. Bennett and Mark Miller/Aldersgate Center to secure and administer treatment, including injection, anesthesia, surgery and hospitalization for my child as named above. The completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Immunization History**

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) } <b>DPT*</b> Tetanus	1 2 3	1 2
or		
Tetanus Diphtheria or } <b>TD*</b>		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubella)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given _____ (most recent)		
Haemophilus influenza b (HIB)		

**Health Care Recommendations by Licensed Physician**

I have examined the above camp applicant within the past two years. Date Examined \_\_\_\_\_

In my opinion, the above's condition  does  does not preclude his/her participation in an active camp program.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

The applicant is under the care of a physician for the following condition(s):  
\_\_\_\_\_  
\_\_\_\_\_

Current treatment (include current medications) \_\_\_\_\_  
\_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion, or concussion \_\_\_\_\_  
\_\_\_\_\_

Does applicant have epilepsy?  Yes  No Does applicant have diabetes?  Yes  No

**Recommendations and Restrictions While at Camp**

Any treatment to be continued at camp \_\_\_\_\_  
\_\_\_\_\_

Any medication to be administered at camp (specific dosages) \_\_\_\_\_  
\_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions \_\_\_\_\_  
\_\_\_\_\_

Any allergies (food, drugs, plants, insects, etc.) \_\_\_\_\_  
\_\_\_\_\_

Activities to be encouraged or limited \_\_\_\_\_  
\_\_\_\_\_

Additional Health Information \_\_\_\_\_

<b>Licensed Physician's Signature</b> _____			
Address _____	_____	_____	Phone _____
<small>Number &amp; Street</small>	<small>City</small>	<small>State</small>	<small>Zip Code</small>
Date of Form Completion _____	*By _____	_____	
<small>*Initial if completed by nurse or physician's assistant.</small>			