

Health History and Examination Form

For Campers and Staff Attending Birch Trail Camp for Girls, Minong, WI.
Please complete and return this form with a current photo by May 15th to:
Birch Trail Camp, PO Box 527, Minong, WI 54859

**Attach
photo
here**

This form, except for the "Health Recommendations of Licensed Healthcare Provider" is to be completed by the parent or legal guardian of minors or by adult participants themselves. Unless otherwise indicated on this form, your signature on this form serves as your permission allowing us to administer medications or provide treatment consistent with the participant's needs, as determined by our health care staff and the provisions of this form.

Name: _____ Session: 1st 2nd 8weeks

Home Address: _____
street address city state zip

Social security number of participant: _____ Gender: male female Date of Birth ___/___/___

Custodial Parent/Guardian: _____ Phone: _____

Home Address: _____
(if different from above) street address city state zip

Home Phone: _____ Business Phone: _____

If not available in an emergency, notify: _____

Relationship: _____ Phone: _____

Home Address: _____
street address city state zip

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

Important - The box below must be completed for attendance!

*** sign here ***

This Health History is correct and complete to the best of my knowledge, and the person herein described has permission to engage in all camp activities except as noted. I give my permission to the medical personnel selected by Birch Trail Camp for Girls, Inc. or its directors to provide routine healthcare: administer "over the counter" medications or prescriptions, order X-rays routine tests and treatment; release any records necessary for insurance or treatment purposes and provide or arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I give permission to the medical personnel selected by Birch Trail Camp For Girls, Inc. or its directors to secure and administer treatment, including but not limited to hospitalization and ordering injections, anesthesia or surgery, for the person described above. This form may be photocopied or faxed in whole or in part as may be appropriate for treatment.

Signature of parent, guardian of camper or minor staff, or of adult staff member

X _____ Date: _____

I agree to abide by any restrictions or limitations placed on my ability to participate in camp activities, as described in this form.

Signature of minor camper/staff member or of adult staff member X _____ Date: _____

The following must be filled in by the parent/guardian of minor camper/staff member, or by an adult staff member. The intent of the information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

HEALTH HISTORY

Medication allergies (list) - describe reaction and management of the reaction.

Food allergies (list)

Other allergies (list) - include insect stings, hay fever, **ASTHMA**, animal dander, etc.

MEDICATIONS

- No medications to be sent to camp
- Listed below are all the medications (prescription and over-the-counter) taken routinely that will need to be administered at camp (attach additional sheets, if necessary):

Name of Medication, as indicated on prescription bottle or other packaging: _____

Amount/Frequency: _____

Duration: _____

Instructions: _____

Reactions: _____

Prescribing Dr. (name and phone number) _____

Conditions requiring Dr. contact: _____

List any medications taken prior to June 1st that will not be taken at camp this summer: _____

NOTE:

➤ **ALL MEDICATIONS MUST GO THROUGH CAMP MEDS.**

➤ All medications, except asthma inhalers and the like, are kept in our health center

➤ **Changing your daughters medications before camp or taking a "medication vacation" can have an adverse effect on your daughters behavior. Our recommendation is that the same medication at the same dose be given for three months prior to camp so your daughter can have the best possible chance for a great summer. If you are planning on changing your daughter's meds prior to the start of camp, please call us to discuss this.**

RESTRICTIONS

The following restrictions apply to camper/staff member described herein:

Dietary

- | | | |
|---|---|--|
| <input type="checkbox"/> Does not eat meat | <input type="checkbox"/> Does not eat pork | <input type="checkbox"/> Does not eat peanuts/tree nut products |
| <input type="checkbox"/> Does not eat poultry | <input type="checkbox"/> Does not eat seafood | <input type="checkbox"/> Does not eat dairy products |
| <input type="checkbox"/> Does not eat eggs | <input type="checkbox"/> Other (describe) | |

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

GENERAL QUESTIONS (please explain any that you check below)

Has/does the participant:	Yes		Yes
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	19. Ever had problems with joints(knees, ankles)?	<input type="checkbox"/>
2. Have a recurring illness/condition?	<input type="checkbox"/>	20. Have an orthodontic appliance that will be brought to camp?	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	21. Have any skin problems (rash, acne, itching)?	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	22. Have Diabetes?	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	23. Have respiratory distress or asthma or used an inhaler for any reason?	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	24. Had mononucleosis in the last 12 months?	<input type="checkbox"/>
7. If female, have an abnormal menstrual cycle?	<input type="checkbox"/>	25. Had problems with diarrhea/constipation?	<input type="checkbox"/>
8. Ever been knocked unconscious?	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>
9. Wear glasses or contacts?	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>
10. Ever had frequent ear infections?	<input type="checkbox"/>	28. Ever have hepatitis or liver disease?	<input type="checkbox"/>
11. Ever passed out during/after exercise?	<input type="checkbox"/>	29. Have any bleeding or blood disorders?	<input type="checkbox"/>
12. Ever been dizzy during/after exercise?	<input type="checkbox"/>	30. Ever have any neurological problems?	<input type="checkbox"/>
13. Ever had seizures?	<input type="checkbox"/>	31. Ever had disorders of the urinary or reproductive tract?	<input type="checkbox"/>
14. Ever had chest pain during/after exercise?	<input type="checkbox"/>	32. Ever had cardiac disease?	<input type="checkbox"/>
15. Ever had high blood pressure?	<input type="checkbox"/>	33. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>
16. Ever had motion sickness?	<input type="checkbox"/>	34. Any other disease or illness not listed above?	<input type="checkbox"/>
17. Ever had back problems?	<input type="checkbox"/>		
18. Have problems with sleepwalking?	<input type="checkbox"/>		

Please explain any "yes" answers, noting the numbers of the questions.

PERSONAL HISTORY (counseling/psychiatric)

Has she/he ever had treatment/counseling with a mental health professional? yes no

Is she/he currently in treatment or counseling? yes no

Name, Address and Phone number of therapist so we may contact him/her if necessary:

Hospitalization within the past year for treatment/counseling of mental health issue(s)? yes no

Reasons for treatment or counseling:

- academic/career eating disorder substance abuse/chemical dependency
family issues/divorce learning disability suicide gesture
other _____

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware.

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

HEALTH RECOMMENDATIONS OF LICENSED HEALTHCARE PROVIDER
To be completed by a licensed healthcare provider

Participant Name: _____

Which of the following has the participant had?

- Measles
- Chicken Pox
- German
- Mumps
- Hepatitis
- Date of last TB test _____
- Influenza B
- Result _____
- Zoster

Please give the date for last immunization:

_____	Vaccine
_____	DTP
_____	TD (tetanus/diphtheria)
_____	Tetanus
_____	Polio
_____	Measles
_____	Rubella
_____	Haemophilus
_____	Hepatitis B
_____	Varicella

Recommendations

I have examined the camp participant identified in this Health History.

Date of last examination: _____

Blood Pressure _____ Weight _____ Height _____ Blood Type(optional) _____

In my opinion, the above applicant is is not able to participate in an active camp program, except as noted below.

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

Current treatment at the time of this report includes:

Recommendations and Restrictions at Camp

Treatment to be continued at camp:

Medications to be administered at camp:

Any medically-prescribed meal plan or dietary restrictions:

Known allergies:

Description of any limitation or restriction of camp activities

**sign
here**

Signature of Licensed Healthcare Provider X _____ Date _____

Name & Title Printed: _____ Phone: _____

NOTE: All physical examinations should occur within 12 months of the campers last day of camp. Please do not sign this if you have not seen the camper within this time period.