Participant name: _____

PARTICIPANT HEALTH HISTORY/PHYSICAL EXAM

american CAMP association®

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health & Association of Camp Nurses

TO PARTICIPANT/PARENT(S)/GUARDIAN(S)/CARE PROVIDER(S): Please follow the instructions below. Attach additional information if needed. All information is kept confidential.

1) Complete Section 1-5 and sign the Participant/Parent/Guardian Authorization

2) Take this form to the participant's healthcare provider.

3) The healthcare provider will complete the RECOMMENDATIONS FOR LICENSED MEDICAL PERSONNEL sections 6-21.

4)After it has been completed & signed, return the form to camp via mail/fax/e-mail (see right) no later than two weeks prior to the start of the session.

easterseals Camp Fairlee

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PLEASE FOLLOW THESE INSTRUCTIONS CARFEULLY. ALL SECTIONS OF THE FORM MUST BE COMPLETED IN THEIR ENTIRETY. INCOMPLETE FORMS MAY NOT BE ACCEPTED AND WILL BE RETURNED WITH A REQUEST FOR ANY MISSING INFORMATION.

SECTION 1: PARTICIPANT INFORMATION

Participant name: _____

☐ Male ☐ Female Birth date: _____ Age on arrival at camp: _____

Participant home address: _____

City: _____ State: _____ Zip code: _____

SECTION 2: EMERGENCY CONTACTS

Please provide all three contacts in order for camp staff to be able to reach someone immediately in the event of an emergency.

Parent/guardian/care provider with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship: _____

Home: _____ Cell:_____ Work: _____

Second parent/guardian/care provider or other emergency contact:

Name: _____ Relationship: _____

Home: _____ Cell:_____ Work: _____

Additional contact in the event parent(s)/guardian(s)/care provider(s) cannot be reached:

Name: _____ Relationship: _____

Home: _____ Cell:_____ Work: _____

Participant name: _____

SECTION 3: HEALTH INSURANCE

The participant is covered by health/hospital insurance: ☐ Yes ☐ No

Insurance company: _____ Subscriber: _____

Policy number: _____ Insurance company phone: _____

Include a copy of your insurance card if appropriate. Copy both sides of the card so information is readable.

SECTION 4: PERMISSION TO TREAT PARTICIPANT/PARENT/GUARDIAN AUTHORIZATION

This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I hereby give permission to the medical personnel selected by Easterseals to order x-rays, routine tests and treatment related to the health of the participant for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the medical personnel selected by Easterseals to hospitalize, secure and administer treatment for, and order injection, anesthesia or surgery for the participant. I give permission to Easterseals staff to provide or arrange any necessary related transportation for the participant. I give permission for the release of any records necessary for insurance purposes. I understand that the information on this form will be shared on a 'need to know' basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of the participant's health record from providers who treat them. These providers may talk with the program's staff about the participant's health status.

Signature of participant (if over 18 years of age): _____ Date: _____

Signature of parent/guardian: _____Date: _____

PRESCRITION MEDICATION REMINDER

All prescribed medications must be in their original bottle or blister pack from pharmacy with the original script from the prescribing physician. All over the counter medications must be brought to camp in their original bottles. Prescription medications with altered labels will not be accepted. The dosage and schedule on the pharmacy label must match the information on the health form signed by the physician. Camp Fairlee staff will not accept pre-poured medication or anything that does not match with the physician's order.

SECTION 5: HEALTHCARE PROVIDERS

Name of participant's primary doctor(s): _____Phone: _____

Name of dentist(s): _____Phone: _____

Participant name: _____

Recommendations for Licensed Medical Personnel

TO LICENSED MEDICAL PERSONNEL:

PLEASE TAKE THE TIME TO THOROUGHLY COMPLETE THIS INFORMATION SO THAT EASTERSEALS MAY PROVIDE THE BEST SERVICE AND APPROPRIATE CARE TO MEET THE NEEDS OF THE PARTICIPANT. ALL SECTIONS MUST BE COMPLETED.

Please sign the Physician Authorization (SECTION 21).

Attach additional information if needed. All information on this form is kept confidential.

SECTION 6: PHYSICAL EXAM

Weight: _____ lbs. Height: _____ ft. _____ in. Blood pressure: _____ /_____

SECTION 7: DIAGNOSIS

The participant is undergoing treatment at this time for the following diagnosis/conditions: (please describe below)

SECTION 8: ATLANTOAXIAL INSTABILITY

Individuals with Down Syndrome who wish to participate in the challenge course, horseback riding or similar activities, must have tested negative for Atlantoaxial Instability. Please describe results below:

X-ray results: _____ Date of testing: _____

SECTION 9: NON-PRESCRIPTION MEDICATIONS

The following non-prescription medications are listed on the camp's standing orders and stocked in the camp health center. They are used on an as needed basis to manage illness and injury. A physician's order is required by the Maryland Nursing Regulations. Please check those the participant may take while attending camp:

- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen (Advil, Motrin)
- ☐ Pseudoephedrine decongestant (Sudafed)
- ☐ Phenylephrine decongestant (Sudafed PE)
- ☐ Guaifenesin cough syrup (Robitussin)
- ☐ Dextromethorphan cough syrup (Robitussin DM)
- ☐ Generic cough drops
- ☐ Sore throat spray
- ☐ Antihistamine/allergy medicine
- ☐ Diphenhydramine (Benadryl)
- ☐ Loratadine (Claritin)
- ☐ Laxatives (Ex-Lax)
- ☐ Milk of Magnesia
- ☐ Antacid
- ☐ Anti-diarrhea
- ☐ Bismuth subsalicylate (Pepto-Bismol)
- ☐ Lice shampoo (Nix, Elimite)
- ☐ Calamine Lotion
- ☐ Hydrocortisone 1%
- ☐ Antibiotic Cream
- ☐ Aloe
- ☐ Sunscreen
- ☐ Bug Spray
- ☐ Oxygen

Participant name: ____

SECTION 10: PRESCRIPTION MEDICATIONS

☐ No daily medications ☐ Will take the following medication(s) while at camp:

Please list all medications the participant is to receive at camp. 'Medication' is any substance a person takes to maintain and/or improve health. This includes vitamins & natural remedies. In order for camp to administer medication(s), please bring them in their original bottles or pharmacy-prepared blister packs with the original label attached. Camp cannot accept pre-poured medications. Provide enough (& one extra dose) of each medication to last the entire time the participant will be at camp.

Name of medication	Reason for taking it	When it is given	Amount or dose given	How it is given
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: ________		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: ________		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: ________		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: ________		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: ________		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _______		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _______		

*****PLEASE COPY THIS PAGE IF MORE MEDICATIONS ARE TAKEN*****

Participant name: _____

SECTION 11: GENERAL HEALTH HISTORY

Has/does the participant:

1. Ever been hospitalized? ..... ☐ Yes ☐ No
2. Ever had surgery? ..... ☐ Yes ☐ No
3. Have recurrent/chronic illnesses? .. ☐ Yes ☐ No
4. Had a recent infectious disease? .... ☐ Yes ☐ No
5. Had a recent injury? ..... ☐ Yes ☐ No
6. Ever had back/joint pain? ..... ☐ Yes ☐ No
7. Have diabetes? ..... ☐ Yes ☐ No
8. Had seizures? (see section 9) ..... ☐ Yes ☐ No
9. Had headaches? ..... ☐ Yes ☐ No
10. Had fainting or dizziness? ..... ☐ Yes ☐ No
11. Had asthma/wheezing/shortness of breath? ..... ☐ Yes ☐ No
12. Passed out/had chest pain during exercise? ..... ☐ Yes ☐ No
13. Had mononucleosis during the past 12 months? ..... ☐ Yes ☐ No
14. If female, have problems with menstruation? ..... ☐ Yes ☐ No
15. Have problems with falling asleep/sleepwalking? ..... ☐ Yes ☐ No
16. Have a history of bedwetting? ..... ☐ Yes ☐ No
17. Have problems with diarrhea/constipation? ..... ☐ Yes ☐ No
18. Have any skin problems? ..... ☐ Yes ☐ No
19. Wear glasses/contacts/protective eyewear? ..... ☐ Yes ☐ No
20. Traveled outside the country in the past 9 months? ☐ Yes ☐ No
21. Does this person have a history or prone to falling ☐ Yes ☐ No

Please explain 'Yes' answers below, noting the number of the question(s). For travel outside the country, please name countries visited and the dates of travel:

SECTION 12: MENTAL/EMOTIONAL/SOCIAL HEALTH

Has the participant:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder? ..... ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ..... ☐ Yes ☐ No
3. During the last 24 months, seen a professional to address mental/emotional health concerns? ..... ☐ Yes ☐ No
4. Had a significant life event that continues to affect the participant's life? ..... ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.)

Please describe any current physical, mental, emotional, social health, developmental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp. The camp may contact you for further information:

Participant name: _____

SECTION 13: DIET/NUTRITION

☐ Regular diet ☐ Vegetarian diet ☐ Lactose intolerant ☐ Gluten intolerant ☐ Other (describe below)

Additional information regarding diet:

SECTION 14: ALLERGIES

☐ No known allergies ☐ The participant is allergic to the following:

Food	Medications	Environment	Other

Please describe below the reaction(s) seen and management of the reaction(s):

SECTION 15: LIMITATIONS/RESTRICTIONS

Are there any camp activities the camper should be exempted from for health reasons? ☐ Yes ☐ No

If 'Yes,' please describe recommendations/adaptations below:

Participant name: _____

SECTION 16: SEIZURES

Please complete this section if the participant is currently having seizures, or has a history of seizures.

Type: _____

Frequency: _____ Duration: _____

Triggers: _____

Date of last seizure: _____ Are the seizures currently under control? ☐ Yes ☐ No

SECTION 17: IMMUNIZATION HISTORY

Please provide the month and year for each immunization. Starred (★) immunizations must include the date to meet ACA standards. Copies of immunization records from healthcare providers or state or local government are acceptable. Please attach them

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis (DTaP/TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Meningococcal meningitis (MCV4)						

Has the participant had chicken pox? ☐ Yes ☐ No If 'Yes,' date of chicken pox:_____

Has the participant had the COVID-19 Vaccine? ☐ Yes ☐ No Date of Second Dose: _____

Date of last tuberculosis (TB) test: _____ Result: ☐ Negative ☐ Positive

★ Date of last tetanus booster (dT or TdaP – **MUST PROVIDE**): _____

SECTION 18: IMMUNIZATION RELEASE

If you are unable to provide sufficient/complete immunization records and/or the participant has not been fully immunized, please sign the following statement/release:

I UNDERSTAND AND ACCEPT THE RISKS TO THE PARTICIPANT FROM NOT BEING FULLY IMMUNIZED.

Signature: _____ Relationship: _____ Date: _____

Participant name: _____

SECTION 19: SPECIALIZED MEDICAL PROCEDURES/TREATMENTS

Will the participant require specialized medical procedures/treatments/therapies to be continued at camp? ☐ Yes ☐ No

(for example: tube feeding, nebulizer treatment, catheterization, insulin injection, etc.)

If 'Yes,' please describe the procedures/treatments/therapies and any precautions below:

SECTION 20: ADDITIONAL INFORMATION

Please provide in the space below any additional information about the participant's health that you think important, or that may affect their ability to fully participate in the camp program:

SECTION 21: PHYSICIAN AUTHORIZATION

I have examined the participant herein described and reviewed the. I have discussed the camp program with the participant and/or their parent(s)/guardian(s). It is my opinion that the participant is physically and emotionally fit to participate in an active camp program (except as noted.) I hereby authorize Easterseals' healthcare staff to perform the specialized medical procedures and distribute the medications listed as prescribed.

Name of licensed provider (please print): _____ Office phone: _____

Office address: _____

Signature: _____ Date: _____