

OCEANWOOD FAMILY CAMP YOUTH HEALTH FORM

This Health Form and the Signed Physical Examination or the campers most recent physical paperwork dated within the past 12 months from the start of camp **must be received by the office two weeks prior to your arrival at camp**

CAMPER INFORMATION

Camper's Name: _____ Date of Birth: _____ Age: _____
Phone Number: _____ Social Security Number: _____ Male () Female ()
Address: _____
City: _____ State: _____ Zip Code: _____

CONTACT INFORMATION (While at Camp & During the Year)

Parent/Guardian #1: _____ Day Phone: _____ Alt: _____
Relationship to Camper: _____ Address: _____
Parent/Guardian #2: _____ Day Phone: _____ Alt: _____
Relationship to Camper: _____ Address: _____

If not available in an emergency, notify:

Name: _____ Phone: _____ Alt: _____
Relationship to Camper: _____ Allowed to Make Medical Decisions: Yes () No ()

INSURANCE INFORMATION & REQUEST FOR YEARLY PHYSICAL*

Insurance coverage for accidents or illness while participating at Oceanwood are the responsibility of the Camper and/or their family. **Please include a copy of your current insurance card.**

Carrier: _____ Policy or Group No. _____
Medicare / Medicaid No. _____ Policy Holder Name: _____
Address of Carrier: _____ City: _____ State: _____ Zip: _____

A CURRENT PHYSICAL (WITHIN THE PAST 12 MONTHS OF THE CAMP START DATE) IS REQUIRED FOR PARTICIPATION AND ACCEPTANCE INTO OCEANWOOD PROGRAMMING

IMPORTANT - MUST BE COMPLETED FOR ATTENDANCE

Authorization: This part should be signed by the parent/guardian if the camper or staff member is under 18. Staff over 18 must sign for themselves.

This health history is correct and complete to be the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by the Director to order x-rays, routine tests, treatment, to release any records necessary for insurance purposes, and to provide or arrange necessary transportation for myself or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the Physician selected by Oceanwood to secure and administer treatment, including hospitalization, for the person named above. I also give permission to trained camp personnel to administer any first aid should a situation requiring medical attention occur while at camp. I further give permission to the camp nurse to administer prescription medication (as noted) and over-the-counter medications. I give permission for this form to be photocopied for off-camp trips. I understand the inherent risks associated with outdoor recreation and camp activities, and do not hold the camp liable for any injuries or death incurred while attending camp.

Signature: _____ **Date:** _____

Printed Name: _____

HEALTH HISTORY: The intent of this information is to provide Oceanwood Medical Staff the background to provide appropriate care. Any changes to this form should be provided to Oceanwood upon arrival. Please provide complete information so that Oceanwood can be aware of your needs.

ALLERGIES: List all known allergies and describe the reaction and management of any reactions

MEDICATION ALLERGIES:

_____	_____
_____	_____

FOOD ALLERGIES:

_____	_____
_____	_____

OTHER ALLERGIES: Include insect stings, seasonal allergies, asthma, animal allergies, etc.

_____	_____
_____	_____

MEDICATION RECORD

This Camper does not take any medications on a routine basis and comes to camp with no medications.

Drug Name Exactly as Dispensed	Dosage & How its Administered	Time(s) Given Camp Administration times are: 8am, 12pm, 4pm, & 8pm	Reason(s) for Medication

PLEASE SUPPLY ANY ORAL SYRINGES, MED SPOONS, OR APPLESAUCE FOR MEDICATION ADMINISTRATION IF NEEDED

RESTRICTIONS & RECOMMENDATIONS WHILE AT CAMP

List any Dietary Restrictions, Medically-Prescribed Meal Plans, or any Special Diets (gluten-free, low salt, etc):

Camper **does not** eat: () Beef () Seafood () Eggs () Pork () Dairy Products () Other: _____

List any **restricted** activities: _____

List any activities the Camper **enjoys**: _____

List any activities the Camper **dislikes**: _____

UNDERSTANDING THE CAMPER

Does the Camper have: () Diabetes () Seizures () ADHD/ADD () Visual Impairment
() Mobility Impairment () Hearing Impairment () Recurring Illness () Other: _____

Please provide any treatment, protocols followed, or any other information on checked items:

Please check if the Camper is subject to any of the following:

- () Sunburn () Urinary Infections () Bedwetting () Constipation () Diarrhea () Vaginal Infections
- () Sinus Infection () Bronchitis () Pneumonia () Frequent Colds () Ear Infections () Sore Throat
- () Asthma () Dizziness/Fainting () Nausea/Vomiting () Anxiety () Panic Attacks () Skin Rash
- () Back Problems () Joint Problems () Hernia () Frequent Headaches () High Blood Pressure
- () Chest pain during/after exercise () Passed out during/after exercise () Heart Abnormalities
- () Sleepwalking () Abnormal Menstrual History () Eating Disorder () Emotional Difficulties

Please explain any items marked off above: _____

*** Is Camper required to carry an EPI pen?** () No () Yes - **Please pack & Provide Dr. Note**

*** Is Camper required to carry an inhaler?** () No () Yes - **Please pack & Provide Dr. Note**

Camper **must:** () **Not** get water in ears () Stay **out** of water () Wear ear plugs when swimming

Has the Camper: () Been hospitalized () Ever had surgery () Ever had a head injury/Been Unconscious

() Had mononucleosis in the past 12 months () Other: _____

Please comment on the above checked items & pack anything required for treatment/management:

Has the participant had any of the following and if so, when?

() Measles: _____ () Chicken Pox: _____ () German Measles: _____

() Mumps: _____ () Hepatitis: _____

() TB Mantoux: _____ Last Test Date: _____ Result: () Positive () Negative

Please let us know of any additional information you feel the camp should be aware of: _____

ADAPTIVE DEVICES

Please check off and **send** any adaptive devices the Camper uses on a regular basis:

() None () Hearing/Communication Aids () AFO's or Braces () Glasses/Contacts () Nebulizer

() Other: _____

Please provide any specific instructions on use and care of any adaptive devices:

Family Physician: _____ **Phone:** _____

Dentist or Orthodontist: _____ **Phone:** _____

MEDICAL RELEASE & EMERGENCY CARE AUTHORIZATION

Please be sure to complete a separate form for each child you are responsible for at camp

Name of Child: _____

Camp Attending: _____

I, the undersigned, give permission of care for the above named Child to the following individual(s):

Printed Name: _____ **Relation:** _____

Printed Name: _____ **Relation:** _____

I hereby authorize the person(s) named above to sign for medical treatment of my above named child between the following dates:

From: _____ **Until:** _____

Here is where I can be reached while my child is attendance at camp with the above named individual:

Phone _____ **Alt #** _____

Address: _____

Parent Name: _____

Signature: _____ **Date:** _____

Witnessed by: _____ **Date:** _____

Witness Phone: _____

PHYSICAL EXAMINATION

Please be accurate & up-to-date within the previous 12 months to the Camper's session date. Physical examination form must be completed & signed by a LICENSED PHYSICIAN or attach the Physicians Form

Camper Name: _____ Session Dates: _____

Height: _____ Weight: _____ BP: _____

In my opinion, the above camper () IS or () IS NOT able to participate in an active camp program

Camper is under the care of a physician for the following condition(s): _____

Current treatment at the time of this examination includes: _____

Any treatment to be continued at camp: _____

RECOMMENDATION & RESTRICTIONS

Known Allergies: _____

Medications to be administered at camp (name, dose, frequency): _____

Any medically prescribed meal plan or dietary restrictions: _____

Description of any limitations or restrictions on camp activities: _____

Please list any additional information: _____

IMMUNIZATIONS & DATES GIVEN

Tetanus/Diphtheria: _____ Tetanus: _____

Polio: _____ DTP: _____

MMR or MMRV: _____ or Measles: _____

or Mumps: _____ or Rubella: _____

Haemophilus Influenza B: _____ Hepatitis B: _____

Varicella: _____ BCG: _____

Rotavirus: _____ Hepatitis A or C: _____

HPV: _____ Meningococcal Influenza: _____

Examining Physician: _____ Date: _____

Signature: _____ Practice Name: _____

Address: _____ Phone #: _____