

Camper's Last Name _____ First Name _____

Birthdate: _____ Session: _____

KABEYUN HEALTH HISTORY & EXAM FORM

Directions: The first two pages are for the camper's parent or guardian to complete. The back page must be completed by a physician, doctor of osteopathy, advanced registered nurse practitioner, or physician's assistant. The actual exam must have been conducted within two years of the start of camp. You may attach the doctor's own exam form, but we need the parental portion completed for each new camp season. Physician's approval for participation, inhaler and epi-pen use must be made for each new season. This completed form must be returned to Kabeyun at least two weeks before the start of the camp season.

Mail to: Kabeyun PO Box 325 Alton Bay, NH 03810

EMERGENCY CONTACT

In case of emergency, please contact: _____

Phone: _____ Cell: _____ Office: _____

Second Emergency Contact: _____

Relationship: _____ Phone: _____ Cell: _____

INSURANCE INFORMATION

Please attach a photocopy of the front and back of your insurance card.

Subscriber's Full Name: _____ Birthdate: _____

Home Address: _____

PARENT'S AUTHORIZATION

The information on the following health history is correct as far as I know, and the boy herein described has my permission to participate in all camp activities, except as noted by me, or by the examining physician. I understand that costs associated with minor medical services at camp will be covered by Kabeyun. Costs associated with visits to the doctor in town, trips to the emergency room, and any other hospital in- or out-patient services are my responsibility.

In signing below I grant permission for the camp nurse to contact health care providers listed on this form regarding any health concerns during the camp season. I give permission to the camp to arrange necessary transportation for my son in seeking appropriate care. In the event I cannot be reached in an emergency, I give permission to the physician selected by the camp director to secure proper treatment, order an injection, hospitalization, anesthesia, or surgery for my son. I agree to the release of any records necessary for treatment, reference, billing, or insurance purposes. This form may be photocopied for trips out of camp.

Signed: _____ Relationship: _____ Date: _____

HEALTH HISTORY

To be completed by a parent or guardian

GENERAL QUESTIONS (Explain "yes" answers below.)

Has / does the participant:

- | | YES | NO | YES | NO | | |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| 1. Had any recent injury, illness or infectious disease? ... | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ever had back problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Ever had problems with joints (e.g., knees, ankles)? .. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have an orthodontic appliance being brought | | | |
| 4. Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | to camp? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have any skin problems (e.g., itching, rash, acne)? ... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious. | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had mononucleosis in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Had problems with diarrhea/constipation? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have problems with sleepwalking? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Have a history of bed-wetting? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had seizures? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Ever had emotional difficulties for which | | | |
| 14. Ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | professional help was sought? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Ever been diagnosed with a heart murmur? | | | | | | |

Please explain any "yes" answers, noting the number of the questions: _____

ALLERGIES: List all known allergies and describe subsequent reaction and effective management. Please attach additional sheets if more space is required.

to medication –

to foods –

other environmental allergies – i.e., insect stings, animal dander, pollen

RESTRICTIONS:

Please identify any activity restrictions due to health matters. Is there anything he cannot do while at camp?

PHYSICIAN'S HEALTH EXAM

Date of exam: _____ (must be within two years of the start date of camp)

The physician's own report form may be attached, but this form must be signed yearly, with updated prescription and dosage information, granting permission to participate in the camp program, and to possess an inhaler, or epi-pen if applicable.

BP: _____ HEIGHT: _____ WEIGHT: _____

IMMUNIZATION HISTORY

Please give all dates of immunization for:							
Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____	_____
or Mumps		_____	_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

TB Mantoux Test
Date of last test _____
Result: Positive Negative

MEDICATIONS

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____

Reason for taking _____

Med #1 _____ Dosage _____

Reason for taking _____

Med #1 _____ Dosage _____

Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does not take during the summer: _____

PHYSICIAN'S AUTHORIZATION

In my opinion, the child described in this report is able to participate in the Kabeyun program.

Signature of Licensed Medical Personnel: _____ Date: _____

Name printed: _____ Phone: _____

INHALER USE: The camper named on this form has the knowledge and skills to safely possess and use an asthma inhaler in the camp setting. The inhaler is listed in the medications section, above.

Signature of Licensed Medical Personnel : _____

EPINEPHRINE AUTO-INJECTOR USE: The camper named on this form has the knowledge and skills to safely possess and use an epinephrine auto-injector in the camp setting. The epi-pen is listed in the medications section above.

Signature of Licensed Medical Personnel : _____