Health History and Examination
Form for Children, Youth and Staff
Attending Holmes Presbyterian
Camp and Conference Center

Dates of Camp Attendance __________________

Mail this form to the address below by two weeks before the start of your camp session.

Holmes Presbyterian Camp and Conference Center
60 Denton Lake Rd
Holmes, NY 12531

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health History (page 1 & 5) must be filled out by parents/guardians of minors.

PLEASE HAVE THE HEALTH CARE PROVIDER COMPLETE AND SIGN PAGES 2, 3 & 4.
This information must be updated annually.

Name ____ Birthdate ____/____/____ Age at camp ______
Last First Middle

Home address ____
Street City State Zip

Social Security number of participant _____-_____-______ Gender: ______ Male ______ Female

Custodial parent/guardian ______________________________ Phone: ______-______-______

Home address ____

Business address ______________________________ Phone: ______-______-______

Second Parent or guardian or emergency contact ______________________________

Home address ______________________________ Phone: ______-______-______

Business address ______________________________ Phone: ______-______-______

If not available in an emergency, notify:

Name ____

Relationship ______________________________ Phone: ______-______-______

Address ____

Insurance Information

Is the participant covered by family medical/hospital insurance? YES ________ NO ________

If so, indicate carrier or plan name ______________________________ Group # ____________

Name of Insured ______________________________ Date of Birth of Insured ____________

Does this policy include dental insurance? YES ________ NO ________

*⁎***Photocopy of front and back of health insurance card must be attached to this form.** Note: Your insurance will be the primary coverage. The Holmes Presbyterian Camp and Conference Center provides coverage for sickness and accidents up to the limits of the policy and will be the secondary coverage. Holmes Presbyterian Camp has a Registered Nurse on staff and on site during our summer camp sessions. Holmes Camp is not a Diabetes Specialty camp and so potential campers with Diabetes will be assessed on a case by case basis. A conversation with the Holmes Camp nurse will be required to make sure that we can provide excellent camping and excellent health care for your child.

Important - These boxes must be complete for attendance

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

I give permission for my child to carry and apply insect repellent with adult supervision. I give permission for my child to carry sunscreen and apply it as necessary during camp sessions at Holmes Presbyterian Camp.

I give permission for me/my child to participate in the activities of Holmes Presbyterian Camp and Conference Center, and for his/her picture to be used in publicity.

Signature of parent/guardian or adult camper/staff member ______________________________

Printed name ______________________________ Date ____________

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer ______________________________

Name ____________ Camp # ____________ Group ____________ Year ____________

PLEASE HAVE THE HEALTH CARE PROVIDER COMPLETE PAGES 2, 3 and 4

Medical Evaluation

I examined ______________________________ (patient's name) _____________ (date of birth) on ____/____/____.

(American Camp Association accreditation requirements specify exams within 12 months of camp attendance. A new exam is not necessarily required for camp attendance.)

Screening/Test Results

Height:	BMI:	Vision/Type of Screening
Weight:	Normal	With glasses R 20/ L 20/
Blood Pressure:	Abnormal	Without glasses R 20/ L 20/
Pulse:	Min:	
HCT/Hgb:	Slight:	Auditory/Type of Screening
Urinalysis:	Mod:	Right Pass/Fail
Gross Dental:	Marked:	Left Pass/ Fail
Lead (Date/Result)	Referral to:	

TB: In high risk group? ✙Yes ✙ No		
TB & other Test Results (sickle Cell, etc)		
Test	Date	Result

Disease Assessment

Yes No		Date of Onset
Asthma	Mild Moderate Severe Exercise Induced Unclassified	
Diabetes	Type I Type II	
Anaphylactic Reaction	Food Insect Latex Other: Explain	
Seizure Disorder	Type:	
Chicken Pox	If yes, when?	
Mumps	If yes, when?	
Other: Please Specify		

Emergency Medications:

Does this person require Epipen: YES NO PRN Inhaler: YES NO
This person has permission to carry: Epipen: YES NO PRN Inhaler: YES NO

(Note: ability to carry implies ability to self administer)

Additional Orders: (As deemed necessary by health care provider to be implemented by R.N. (i.e. peak flows, blood draws/lab work, dressing changes, cast care, feed via GT tube, etc):______________________________

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Limitations on Activities: Swimming ______ Diving ______ Hiking ______ Athletics ______Other______________________________
Explain above:______________________________

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Holmes Presbyterian Camp and Conference Center Health History

Individualized Orders for ___________________________________ Date completed _______________________

The following Standard "Over the Counter" PRN Medications are available in the Health Center to be administered per the family physician's instructions.

This page must be completed by the Physician. Please cross out any OTC medications not desired for this camper.

Drug Generic equivalents may be used	Route	Dosage	Schedule and Indications	Comments
Diphenhydramine	PO	As per pkg by wt and age	Allergies or Allergic Reactions	
Burn Gel	Topically	Apply to minor burns	Minor Burns	
Tums	PO	As per pkg by wt and age	No BM x 3 Days	
Acetaminophen	PO	As per pkg by wt and age	Temp. $\geq$ 100° or Pain	
Ibuprofen	PO	As per pkg by wt and age	Temp. $\geq$ 100° or Pain	
Hydrocortisone	Topically	Apply to effected area 3x /day	Itch	
Cough Drops	PO	As per pkg by wt and age	Cough or Sore Throat	
Triple Antibiotic	Topically	Apply to effected area 3x /day	Scrapes or Cuts	
Bacitracin	Topically	Apply to effected area 3x /day	Scrapes or Cuts	

Non Prescription and Prescription Medications (Please complete with patient's current regimen for both scheduled and prn medications. Use 2nd page if needed) this includes vitamins, inhalers, ear and eye drops. ***Medications must be in the original labeled bottle with directions for administration.***

Drug	Route	Dosage	Schedule and Indications	Comments

Please Record Immunization Dates on Page 4. A copy of a current immunization record is acceptable.

I certify that I have on this date examined the above named camper and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this camper to participate in physically strenuous activities.

Signature of Physician ____ Date of Examination ________________

Please Print: Physician's Name ______________________________________ License # ___________________________

Address____ Phone # ____________________________

Camper Name __________________________ **Week Attending___________________**

Immunization History

(**Please Provide Month, Day and Year of Immunization**) Or attach a copy of physician report of immunizations.

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DPT/Hib						
DTaP						
DT/Td						
OPV						
IPV						
MMR						
HiB						
Hep B						
Hep A						
Varicella						
TDap						
PCV						
HPV						
MCV						
Influenza:						

HIPPA Privacy Statement: Permission to Release Confidential Information **Parents please complete!!!**

I give ____ permission to release confidential health information to
(Name of Medical Practice) Holmes Presbyterian Camp and Conference Center regarding this person.

Date:_______________________ Parent/Guardian Signature____

For Camp Use Only

Screening checklist completed _____time ____ am/pm Updates/additions to health history noted? ___ YES ___ NO

Meds received ______________________________ Current Health needs identified _________________________________

____ Screened by ____

Camper Name ________________________ **Week Attending**__________________

The following information must be filled in by the parent/guardian or adult camper or staff member.

The intent of this 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 the camp health personnel upon participants arrival in camp. Provide complete information so that the camp can be aware of your needs.

Camper's Health Care Provider Name: ____________________________________ Phone: _______-________-__________

Address: ____

Camper's Family Dentist/ Orthodontist: __________________________________ Phone: _______-________-__________

Address: ____

Emergency Medical Information (check yes or no for each item)

YES ____ N0 ____ Allergy to a medicine, food, plant animal or insect
YES ____ N0 ____ Do you have an epinephrine pen?
YES ____ N0 ____ Any condition which requires special care, medication or diet?
YES ____ N0 ____ Asthma
YES ____ N0 ____ Contact Lenses

YES ____ N0 ____ Seizure Disorder
YES ____ N0 ____ Diabetes
YES ____ N0 ____ Heart Trouble
YES ____ N0 ____ Bleeding Disorder
YES ____ N0 ____ Dentures
YES ____ N0 ____ Bonded Teeth

Explain any of the above ____

Medical History

Serious Illness YES ____ N0 ____ Date __________ Details ______________________________________
Serious Injury YES ____ N0 ____ Date __________ Details ______________________________________

Does your child have frequent: (circle yes or no)
Y / N Eye Infections
Y / N Ear Infections
Y / N Throat Infections
Y / N Respiratory Infections
Y / N Urinary Tract Infections
Y / N Vaginal Infections

Does your child have: (circle yes or no)
Y / N Heart Murmur
Y / N Rheumatic Fever
Y / N Stomach/Intestinal Problems
Y / N Menstrual Problems
Y / N Hernia
Y / N Back or Joint Pains

Explain any of the above ____

Health History

Has this person had Chicken Pox? YES ____ N0 ____ If Yes, when? Date ______________________________
Has this person had Mumps? YES ____ N0 ____ If Yes, when? Date ______________________________
Has this person been exposed to a contagious disease with the past three weeks? YES __ N0 ____ If Yes, when? Date ___________
Has this person had lice in the past six months? YES ____ N0 ____ If Yes, when? Date ______________________
If applicable, has this person started menstruation? YES ____ N0 ____ Has she been told about menstruation? YES ______ N0 ____
Does this person take any medication on a regular basis? YES ____ N0 ____ If Yes, when? Date ______________________

Allergies List all known. Describe reaction and management of the reaction. Medication, food, environment including insect stings, hay fever, etc. ____

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Restrictions

The following restrictions apply to this individual.
Dietary
____Vegetarian or Vegan describe ____
____Dairy Allergy ____Milk Product Allergy ____Egg Allergy ____Gluten Free ____Nut Allergy
____Other - If any of the above are checked, please describe so our food service can be prepared______________________

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

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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.

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