2010 PRESBYTERIAN CAMP AND CONFERENCE CENTER
HEALTH HISTORY AND EXAMINATION FORM

This side is to be completed and signed by parent/guardian.

Name______________________________________Sex_____Age_____Birthdate_________S.S.#____________
Last First
Home Address____Phone ( )______________________
Street & Number City State Zip
Child lives with:_____father__________________Work phone ( )_____________Cell phone ( )__________
_____mother__________________Work phone ( )_____________Cell phone ( )__________
_____other (please specify)___________________Work phone ( )_____________Cell phone ( )__________

Additional emergency contact in case we are unable to reach YOU:_____________________________________
____
Name:____ Phone ( )____________________________________
(Activities to be either encouraged or limited (Specify)____
Dietary modifications____
Hospitalizations or serious injuries (Dates)____
Has psychiatric counseling or hospitalization been needed? ____
Medically significant allergies (foods, plants, insects, drugs and action you wish us to take)___________________
____
____
CURRENT MEDICATIONS:____
____
Any recurring medical problems: Bedwetting?____________________Homesickness?______________________
Headaches?_________Ear infections?__________Stomachaches?__________Other________________________
For females, has she menstruated?________________If not has she been told about it?_______________________
Any other health related information you wish camp personnel to have:____________________________________
Dentist/orthodontist___________________________________ Phone ( )_______________________________
Name of family physician_______________________________ Phone ( )_______________________________
Name of Insurance holder_______________________________ Date of birth ___________________________
Medical/hospital insurance carrier_________________________ Policy or group #________________________
Prescription insurance carrier ____________________________ Policy or group #________________________
PLEASE ATTACH A COPY (front & back) OF YOUR INSURANCE AND PRESCRIPTION CARDS.

Please notify camp if child was exposed to any contagious illness three weeks prior to camp.
In signing this application, I hereby certify that the above information is correct and give permission for the use of photographs including my son or daughter in camp publicity; for my son or daughter to be transported in privately owned vehicles to and from public transportation or for approved out-of-camp activities, and for the release of medical records in case of accident or illness. In case of medical emergency, I understand that every effort will be made to contact parents or guardians of camper. In the event that I cannot be reached, I hereby give permission to the physician selected by the camp director to hospitalize, secure treatment for, and to order injection, anesthesia or surgery for my child, as named herein.
This completed form may be photocopied for trips out of camp. The camp carries secondary health and accident insurance--your insurance is primary. A physical is required every 2 years. If you want to use this physical for next year, please make a copy and keep it for next summer, we do not keep forms from year to year!
_____ I give permission for my child to be treated as per the camp's standing orders with the following exceptions:____
Standing orders are available from the camp on request or can be viewed at registration.

SIGNATURE OF PARENT OR GUARDIAN ______________________________________
BRING completed and **SIGNED** form to camp **WITH YOU** as your admission ticket. **(over)**

IMMUNIZATION HISTORY

Please give month and year of basic series and of most recent booster______________________
Diphtheria, Pertussis, Tetanus, "DPT" 1.______________2.______________3._____________
Most recent boosters or TD or Tetanus Toxoid____
Oral Polio (Sabin) *TOPV______________________Injectable Polio (Salk)_______________
Measles, Mumps, Rubella, "MMR"____
Most recent TB test (not required, list date if you have had one)__________________________
Hepatitis B Series 1.________________2.________________3._________________________
Haemophilus Influenza B (HIB)____
Other:____

TO BE COMPLETED BY A LICENSED PHYSICIAN:

Date Examined (must be within the past two years)____________________________________

Height:_________________Weight:_________________Blood Pressure:__________________

The applicant is under care of a physician for the following condition(s):___________________
____
____

Allergies to (food, drugs, plants, insects, etc.):____
____
Dietary restrictions:____
Activity restrictions:____
Additional Health Information:____
____
____

Licensed physician's signature____
Address____
Phone number (   )____
Date of form completion____________________*by___________________________________
If completed by nurse or physician's assistant

For camp use only

Screening Record
Date Screened____Time__________
Meds received____
____
Updates/additions to health history noted ___ Yes ___ No ___ None required
Current health needs identified____
____
Observational notes____
____
Screened by_________________________________