

Camp Morasha Health History and Physical Exam Form
 Based on forms developed by the American Camping Association and the American Academy of Pediatrics

Winter Address
 1118 Avenue J
 Brooklyn, NY 11230
 (718) 252-9696

Summer Address
 274 High Lake Road
 Lakewood, PA 18439-3968
 (570) 798-2781



County/State
 Home
 Social Security Number
 Gender: [] Male [] Female
 Name:
 Date of Birth:
 Age:
 Home Address:
 Social Security Number:
 Gender: [] Male [] Female
 Name:
 Phone:
 Cell:
 Home Address:
 Business Address:
 Business Phone:
 Name:
 Phone:
 Cell:
 Home Address:
 Business Address:
 Business Phone:
 Name:
 Phone:
 Cell:
 Home Address:
 Business Address:
 Business Phone:
 Is the participant covered by family medical/hospital insurance? [] Yes [] No
 If so, indicate carrier or plan name: _____ Group #: _____

Name: _____ Date of Birth: _____ Age: _____

Home Address: _____

Social Security Number: _____ Gender: [] Male [] Female

Name: _____ Phone: _____ Cell: _____

Home Address: _____

Business Address: _____ Business Phone: _____

Name: _____ Phone: _____ Cell: _____

Home Address: _____

Business Address: _____ Business Phone: _____

Name: _____ Phone: _____ Cell: _____

Home Address: _____

Business Address: _____ Business Phone: _____

Is the participant covered by family medical/hospital insurance? [] Yes [] No

If so, indicate carrier or plan name: _____ Group #: _____

**Photocopy of front and back of insurance card
 must be attached to this form.**

Name of family physician: _____ Phone: _____

Name of family dentist: _____ Phone: _____

Name of family orthodontist: _____ Phone: _____

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give my permission to the camp to provide, seek and consent to routine health care, administration of prescribed medications and emergency treatment for me/my child, as may be necessary, including, but not limited to, X-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

It is my intention that the camp be treated as acting in loco parentis if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of

disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR 164.510(h)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

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

**Signature of parent/guardian
 or adult camper/staff member:** _____

Printed Name: _____ **Date:** _____

HEALTH
HISTORY

To be completed by parents:

List all known allergies and describe reaction and management of the reaction:

Medication Allergies

List: _____

Food Allergies

List: _____

Other Allergies

List: _____

It is imperative that the infirmary have a list of all medications your child will be on during the camp season, including over-the-counter and non-prescription drugs. Bring enough medication to last the entire time in camp. Keep it in the original packaging that identifies the prescribing physician, the name of the medication, the dosage and frequency of administration.

MEDICATIONS
BEING TAKEN

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med#1 _____ Dosage _____ Times taken each day _____

Reason for taking _____

Med#2 _____ Dosage _____ Times taken each day _____

Reason for taking _____

Med#3 _____ Dosage _____ Times taken each day _____

Reason for taking _____

Attach additional pages for more medications.

Identify medications taken during the school year that participant does/may not take during the summer:

RESTRICTIONS
TO ACTIVITY

The following restrictions apply to this individual:

I am aware that no medications, prescription and non-prescription, are allowed in bunks and that all medications must be stored at and administered by the infirmary. I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of parent/guardian
or adult camper/staff member: _____

Signature of camper: _____

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (Camp Morasha requires each camper/staff member to have an annual exam.)

HEALTH
HISTORY

BP: _____ Weight: _____ Height: _____

The above applicant is is not able to participate in an active camp program.

The applicant is under the care of another physician/psychologist for the following conditions:

Recommendations and Restrictions at Camp

Treatment to be continued at camp _____

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

Known medication allergies _____

Known food allergies _____

Other allergies _____

Description of any limitation or restriction on camp activities _____

Additional information for health care staff at the camp _____

- | | |
|--|--|
| <input type="checkbox"/> Hospitalization or surgery | <input type="checkbox"/> Diarrhea or constipation |
| <input type="checkbox"/> Recent illness or injury | <input type="checkbox"/> Bedwetting or sleepwalking |
| <input type="checkbox"/> Chronic or recurrent illnesses, especially: | <input type="checkbox"/> Skin problems (acne, eczema, etc.) |
| <input type="checkbox"/> diabetes or asthma | <input type="checkbox"/> Abnormal menstrual history |
| <input type="checkbox"/> any bleeding tendencies | <input type="checkbox"/> Eating disorder (anorexia, bulimia) |
| (Von Willebrand or hemophilia) | <input type="checkbox"/> Emotional difficulties for which professional help was sought |
| <input type="checkbox"/> Head injury, headache or loss of consciousness | <input type="checkbox"/> Wear glasses, contact or protective eyewear |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Wears orthodontic appliance |
| <input type="checkbox"/> Heart murmur or high blood pressure | |
| <input type="checkbox"/> Dizziness, headache or loss of consciousness after exercise | |

Please explain any checked items:

Please list below any past medical history that might be relevant to your patient's care while in camp. Use the checklist as well (use additional paper if necessary):

General
Questions

Which of the following has the participant had?

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

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

Please give all dates of immunization for:

Vaccine	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DPT		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
or Measels		_____	_____	_____	_____	_____	_____
or Mumps		_____	_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (Chicken pox)		_____	_____	_____	_____	_____	_____

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.

Signature of licensed medical personnel: _____
Printed Name: _____
Title: _____
Address: _____
Phone: _____
Date: _____