Dear Parents/Guardians,

Please complete this entire medical form. We ask that each camper have had a physical exam by a health professional sometime within the past 24 months. Take this form to your health professional to complete. If your child has had a physical for school or athletics, you may photocopy it and attach it to our form, but please, answer all the questions on our form as well.

**We May Need More Detailed Information:**

Name of your child: ________________________________________

1) If you will be leaving medications for us to administer, please use the space below to describe symptoms or behaviors that are connected to the condition being treated. Please let us know how you respond to these symptoms and behaviors. We would like to offer your child consistent, familiar care.

2) Does your child have a history of anxiety, bedwetting, homesickness, or other non-medical concerns? Please explain and share your suggestions with us.

The information that you share with us is confidential and will be stored with your child's medical form.

Thank you for your help.
The Maine Conservation School

Health History and Examination Form
for Children, Youth and Adults
Attending Camp

Suggested for resident camp use.

Dates of Camp Attendance____________________

Mail this form to the address below by __________
(date)
The M A I N E Conservation School
PO Box 188
Bryant Pond, Me 04219

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 (first three pages) must be filled out by parents/guardians of minors or by adults themselves. Update required annually. Health exam (back page) must be completed by approved licensed medical personnel at least every two years.

Name_______________________________________________ Birth date_____________ age at camp____
*Last* *First* *MI*
Home address____________________________________________________________________________
*Street* *City* *State* *Zip code*
Social security number of participant________________________ Gender ☐ Male ☐ Female
Custodial parent/guardian_________________________________ Phone____________________________
Home address (if different from above)_______________________________________________________
Business address ________________________________________ Phone____________________________
If not available in an emergency notify:
Name___________________________________________________________________________________
Relationship____________________________________________ Phone____________________________
Address_________________________________________________________________________________
*Street* *City* *State* *Zip code*
Insurance Information
Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No
If so, indicate carrier and plan name__________________________________ Group#_________________

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

**Important - These boxes must be complete for attendance***

**Parents/Guardian Authorization:** This heath history is correc and complete as far as I know. The person herein described has permission to engage I 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 for 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.

Signature of parents/guardian or adult camper/staffer_______________________________________________
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____________________________ Date_____________________

**If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

## Health History

The following information must be filled in by the parent/ guardian, or adult or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate cash. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

**Allergies** List all known — Describe reaction and management of the reaction

**Medication allergies (list)**

______________________ ______________________________________
______________________ ______________________________________
______________________ ______________________________________
______________________ ______________________________________

**Food allergies (list)**

______________________ ______________________________________
______________________ ______________________________________
______________________ ______________________________________
______________________ ______________________________________

**Other allergies (list) - include insect stings, hey fever, asthma, animal dander, etc.**

______________________ ______________________________________
______________________ ______________________________________
______________________ ______________________________________

**MEDICATIONS BEING TAKEN**

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

☐ This person takes NO medications o a routine basis.

☐ This person takes medications as follows:

Med #1_________________Dosage____________ Specific times taken each day____________
Reason for taking_________________________________________________________________
Med #2_________________Dosage____________ Specific times taken each day____________
Reason for taking_________________________________________________________________
Med #3_________________Dosage____________ Specific times taken each day____________
Reason for taking_________________________________________________________________

Attach additional pages for more medications

Identify any medications taken during the school year that participant does/may take during the summer_____________________

**RESTRICTIONS**

The following restrictions apply to this individual.

### Dietary

☐ Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs
☐ Does not eat poultry. ☐ Does not eat seafood ☐ Does not eat dairy products
☐ Other (describe) ______________________________________________

______________________________________________

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

______________________________________________________________________
______________________________________________________________________

**General Questions (**Explain "yes" answers below) **Yes No**

| Question | Yes | No | Question | Yes | No |
|---|---|---|---|---|---|
| 1. Had any recent injury, illness or infectious disease? | ☐ | ☐ | 16. Ever had back problems? | ☐ | ☐ |
| 2. Have a chromic or reoccurring illness/condition? | ☐ | ☐ | 17. Ever had problems with joints (knees,, ankles)? | ☐ | ☐ |
| 3. Ever been hospitalized? | ☐ | ☐ | 18. Have an orthodontic appliance being brought to camp? | ☐ | ☐ |
| 4.Ever had surgery? | ☐ | ☐ | 19. Have any skin problems (itching, rash, acne)? | ☐ | ☐ |
| 5.Have frequent headaches? | ☐ | ☐ | 20. Have diabetes? | ☐ | ☐ |
| 6. Ever had a head injury? | ☐ | ☐ | 21. Have asthma? | ☐ | ☐ |
| 7. Ever been knocked unconscious? | ☐ | ☐ | 22. Had mononucleosis in the past 12 months? | ☐ | ☐ |
| 8.Wear glasses, contacts or protective eyewear? | ☐ | ☐ | 23. Had problems with diarrhea/constipation? | ☐ | ☐ |
| 9. Ever had frequent ear infections? | ☐ | ☐ | 24. Have problems with sleepwalking? | ☐ | ☐ |
| 10. Ever passed out during pr after exercise? | ☐ | ☐ | 25. If female, have an abnormal menstrual history? | ☐ | ☐ |
| 11.Ever been dizzy during are after exercise? | ☐ | ☐ | 26. Have a history of bed-wetting? | ☐ | ☐ |
| 12. Ever had seizures? | ☐ | ☐ | 27. Ever had an eating disorder? | ☐ | ☐ |
| 13. Ever had chest pain during pr after exercise? | ☐ | ☐ | 28. Ever had emotional difficulties for which professional help was sought? | ☐ | ☐ |
| 14.Ever had high blood pressure? | ☐ | ☐ | | ☐ | ☐ |
| 15. Ever been diagnosed with a heart murmur? | ☐ | ☐ | | | |

**Please explain any "yes" answers, noting the number of the questions.**

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

| Which of the following has the participant had? | Please give all dates of immunization<br>Vaccine Dates | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr |
|---|---|---|---|---|---|---|
| ☐ Measles | DPT | _____ | _____ | _____ | _____ | _____ |
| ☐ Chicken pox | TD (tetanus/diphtheria | _____ | _____ | _____ | _____ | _____ |
| ☐ German measles | Tetanus | _____ | _____ | _____ | _____ | _____ |
| ☐ Mumps | Polio | _____ | _____ | _____ | _____ | _____ |
| ☐ Hepatitis A | MMR | _____ | _____ | _____ | _____ | _____ |
| ☐ Hepatitis B | or Measles | _____ | _____ | | | |
| ☐ Hepatitis C | or Mumps | _____ | _____ | | | |
| | or Rubella | _____ | _____ | | | |
| TB Mantoux Test | Haemophilus Influenza B | _____ | _____ | _____ | _____ | |
| Date of last test?_________________ | Hepatitis B | _____ | _____ | _____ | | |
| Results: ☐ Positive ☐ Negative | 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.**

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

Name of family physician___________________________________________ Phone______________________________________

Address_____________________________________________________________________________________________

Name of family dentist/orthodontist__________________________________ Phone______________________________________

Address_____________________________________________________________________________________________

## Health Care Recommendations by Licensed Personnel

I examined the individual on _______________(ACA accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.

BP_______________ Weight__________________ Height____________________

In my opinion, the above applicant ____is ____ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions

## Recommendations and Restrictions at Camp

Treatment to be continued at camp

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

Any medically-prescribed meal plan or dietary restrictions

Known allergies

Description of any limitations or restrictions on camp activities

Additional information for health care staff at the camp

**Signature of Licensed Medical Personnel**

Printed__________________________________________ Title_______________________________

Address_____________________________________________________________________

Phone________________________________________________________ Date____________________

***For camp use only***

Screening Record

Date screened____________________________________________ Time _________________am/pm

Meds received________________________________________________________________

Updates/additions to health history noted _______Yes ______No _______None required_______

Current health needs identified______________________________________________________

Observational notes_________________________________________________________________

Screened By_______________________________________________