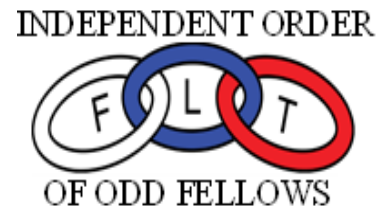




Camp NEOFA
Health History Form
 Montville, Maine
2018 Camping Season



Forms due no later than June 15th to:
 Alice Bennett
 P.O. Box 122
 Shelburne, VT 05482

Mo./Day: Dates will attend camp _____, 2018 to _____, 2018

Camper Name: _____
 _____ First Middle Last
 Male Female Date of Birth _____ Age on Arrival at Camp _____ .

To Parents/Guardian: Please follow the instructions below. If additional space is needed, please attach separate sheets.

- 1) Complete this form and make one more copy.
- 2) Give the Original, signed form to the person who gave it to you.
- 3) Have the last page -4- (of Health History Form done by Licensed Medical Personnel) completed by a licensed medical professional – a medical exam MUST have been conducted within 12 months of camp attendance.

Camper's Home Address _____
 _____ (Street Address) _____ (City) _____ (State) _____ (Zip /Postal Code)

Parent/Guardian with legal custody to be contacted in case of injury/emergency
 Relationship _____
 Name _____ to Camper _____ Phone #(s) _____

Home Address _____
 _____ (Street Address) _____ (City) _____ (State) _____ (Zip/Postal Cod)

Second Parent/Guardian or Other Emergency Contact:
 Relationship _____
 Name _____ to Camper _____ Phone #(s) _____

Additional Contact in Event Parents/Guardians cannot be reached:
 Email address _____
 Relationship _____
 Name _____ to Camper _____ Phone #(s) _____
 Email address _____

Allergies: No Known Allergies. This camper is allergic to: Food Medicine The environment (*insect stings, hay fever, etc.*) Other
 (*Please describe below what the camper is allergic to and the reaction seen*)

Restrictions: I have reviewed the programs of the camp and feel the camper can participate without restrictions.
 I have reviewed the programs of the camp and feel the camper can participate with the following restrictions or adaptations:(*please describe below*)

Medical Insurance Information:

The camper is insured by family medical/hospital insurance. Yes No
 Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company _____ Policy Number _____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize secure proper treatment for and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status

Signature of Custodial parent/Guardian _____ Date _____ Relationship to Camper _____

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

Camp NEOFA and/or Northeast Odd Fellows Association is not responsible for any non-work related expenses

MEDICATIONS BEING TAKEN:

Please list ALL medications (including over-the-counter or non-prescription 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 medication on a routine basis.

This person takes medications as follows"

Med #1 _____ Dosage _____ Specific time taken each day _____

Reason for Taking: _____

Med #2 _____ Dosage _____ Specific time taken each day _____

Reason for Taking: _____

Med #3 _____ Dosage _____ Specific time taken each day _____

Reason for Taking: _____

Attach addition pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer. _____

GENERAL QUESTIONS: (Explain "yes" answers below.)

Has/does the participant:	YES	NO		YES	NO
1) Had any recent injury ?	___	___	17) Ever been dizzy during or after exercise?	___	___
2) Have a chronic or recurring illness/condition?	___	___	18) Ever had high blood pressure?	___	___
3) Ever been hospitalized?	___	___	19) Ever been diagnosed with a heart murmur?	___	___
4) Ever had surgery?	___	___	20) Ever had back problems?	___	___
5) Had a recent illness?	___	___	21) Ever had problems with joints (knees, ankles)	___	___
6) Had a recent infectious disease?	___	___	22) Have an orthodontic appliance being brought to camp?	___	___
7) Ever had a head injury?	___	___	23) Have any skin problems (itching,rash,acne)?	___	___
8) Ever been knocked unconscious?	___	___	24) Had mononucleosis in the past 12 months?	___	___
9) Have asthma, wheezing, shortness of breath?	___	___	25) Had problems with diarrhea/constipation?	___	___
10) Wear glasses, contacts or protective eyewear?	___	___	26) Have problems with sleepwalking?	___	___
11) Ever had frequent ear infections?	___	___	27) If female, have abnormal menstrual history?	___	___
12) Have diabetes?	___	___	28) Have a history of bedwetting?	___	___
13) Have seizures?	___	___	29) Ever had an eating disorder?	___	___
14) Have headaches?	___	___	30) Ever had emotional difficulties for which professional help was sought?	___	___
15) Ever passed out during or after exercise?	___	___	31) Traveled outside country in past 9 months?	___	___
16) Ever had chest pain during or after exercise?	___	___			

PLEASE EXPLAIN ANY YES ANSWERS, NOTING THE NUMBER OF THE QUESTIONS.

Which of the following
Has the participant had?

Please give all dates of immunizations for:

Vaccines

Dates

Mo/Yr

Mo/Yr

Mo/Yr

Mo/Yr

Mo/Yr

Mo/Yr

- ___ Measles
- ___ Chicken Pox
- ___ German measles
- ___ Mumps
- ___ Hepatitis A
- ___ Hepatitis B
- ___ Hepatitis C

- 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 ___

Copy of School Immunization Record

No Immunizations due to religious, philosophical or because it was
Medically inadvisable. (Need a signed parental letter)

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.

Mental, Emotional and Social Health: Check Yes or No for each statement.

Has the camper:

YES NO

- 1) Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?
- 2) Ever been treated for emotional or behavioral difficulties or eating disorder?
- 3) During the past 12 months, seen a professional to address mental/emotional health concerns?
- 4) Had a significant life event that continues to affect the camper's life?

___	___
___	___
___	___
___	___

PLEASE EXPLAIN YES ANSWERS IN THE SPACE PROVIDED.

The following non-prescription medications may be stocked in the camp Health Center and are used on an as-needed basis to manage illness and injury. **Cross out those the camper should not be given.**

- | | |
|---|--|
| Acetaminophen (Tylenol) | Ibuprofen (Advil, Motrin) |
| Phenylephrine decongestant (Sudafed PE) | Pseudoephedrine decongestant (Sudafed) |
| Antihistamine allergy medicine | Guaifenesin cough syrup (Robitussin) |
| Diphenhydramine antihistamine allergy medicine (Benadryl) | Dextromethorphan cough syrup (Robitussin DM) |
| Sort throat spray | Generic cough drops |
| Lice shampoo or cream (Nix or Elimite) | Antibiotic cream |
| Calamine lotion | Aloe |
| Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) | Laxatives for constipation (Ex-Lax) |

Name of Family Physician _____ Phone _____

Address _____

Name of Family Dentist/Orthodontist _____ Phone _____

Address _____

Health Care Recommendations by Licensed Medical Personnel:

I examined this individual on _____ (ACA accreditation requirements specify exams within 12 months of camp attendance).

BP _____ Height _____ Weight _____

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 limitation or restriction on camp activities _____

Additional information for health care staff at the camp _____

SIGNATURE OF LICENSED MEDICAL PERSONNEL _____

Printed _____ Title _____

Address _____

Phone _____ Date _____