MEDICAL FORM 2016

The first 3 pages are to be filled out by the parent and the last page is to be filled out by a physician

Camper Name (Last, First) _____ Sex ___ Birthdate _____

Address _____Home Phone _____

_____

Mother's Name (Last, First) _____

Father's Name (Last, First) _____

Father's Work Phone _____Mother's Work Phone_____

Father's Cell Phone _____Mother's Cell Phone_____

In the event of an emergency in which a parent cannot be reached, please contact:

Name _____

Telephone _____ **Relationship** _____

HEALTH HISTORY (INDICATE YEAR)	**ALLERGIES**	**TENDENCY TO**
Chicken Pox _____	Eczema_____	Bed Wetting_____
German Measles _____	Hay Fever_____	Fainting_____
Measles _____	Poison Ivy, etc_____	Hives_____
Mumps _____	Insect Stings_____	Stomach Upsets_____
Rheumatic fever _____	Penicillin_____	Headaches_____
Other _____	Other_____	Other_____

ASTHMA

Does your child suffer from asthma? []Yes []No *If yes, please answer the following questions:*
What is your child's baseline peakflow?_____
What medications is your child on?
A) Oral_____
B) Inhaled_____
Has your child been to the hospital for an asthma attack in the last 2 years? []Yes []No

Operations or Serious Injuries (Please give dates and be specific) _____

_____

Chronic or Recurring Illnesses _____

Activity Restrictions _____

Recommendations (special diet, medicine, etc.) _____

_____

_____

Has the camper ever been diagnosed as ADD or ADHD?_____ *If yes, complete the rest of this section.*

Does he/she take medication for this condition during the school year?_____ *If yes*, what? _____

Will he/she be taking said medication during the summer? _____

If not, please provide reason: _____

MEDICATIONS

List any medications the child will be taking at camp:

Medication (name)_____ Dosage _____ How often _____

Medication (name)_____ Dosage _____ How often _____

Medication (name)_____ Dosage _____ How often _____

Medication (name)_____ Dosage _____ How often _____

Please describe condition requiring this medication:

Activity Restrictions:

Please be sure to notify us of any prescription changes.

PLEASE NOTIFY THE CAMP IF THIS CAMPER WAS EXPOSED TO LICE OR ANY COMMUNICABLE DISEASES DURING THE THREE WEEKS PRIOR TO CAMP OR HAD A RECENT INJURY.

PARENT'S AUTHORIZATION: This health history is correct, as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physician. I hereby give permission to the physician selected by the camp director to order x-rays, routine tests, and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. I hereby authorize providers to bill my insurance companies for any expenses incurred for off-camp medical treatment. I further authorize the camp medical staff to discuss any medical conditions with the director, his/her designee, or members of the camp staff when the medical staff, in its sole discretion, believes such communication to be in the best interest of the child. Authorization is hereby granted to the outside health provider to share all medical information with camp medical personnel which will aid in my child's recovery.

Parent's Signature_____ **Date**_____

Insurance Information

In the unlikely event your child will need prescription, dental, or medical treatment at a local facility, it is imperative that we have your insurance and credit card information. Please attach copies of insurance, dental, and prescription cards to this form.

*****CREDIT CARD & INSURANCE INFORMATION IS REQUIRED *****
Must be either a Visa or MasterCard

In the unlikely event that the pharmacy/doctor/dentist does not accept my medical/drug/dental card, I hereby authorize Island Lake to use the following credit card for purposes of paying for such charges. This may also be used to cover my co-pay.

Card Number (Visa or MasterCard only):_____ Expiration:_____ Security ID_____

Name on card:_____ Signature:_____

Insurance guarantor's Date of Birth: _____ Workplace:_____

Health Insurance Card
Front

Health Insurance Card
Back

Hospital Insurance Card
Front

Hospital Insurance Card
Back

Prescription Insurance Card
Front

Prescription Insurance Card
Back

Dental Insurance Card
Front

Dental Insurance Card
Back

THIS PAGE TO BE COMPLETED BY PHYSICIAN

MEDICAL EXAMINATION

Eyes_____
Glasses_____
Ears_____
Nose_____
Throat_____
Heart_____
Lungs_____
Abdomen_____
Hernia_____
Teeth_____

Height_____ Weight_____
(Circle One) Overweight Underweight Normal
Extremities_____
Posture (spine)_____
Skin_____
Physical Disability_____
Emotional Disability_____
Allergies (Please specify)_____

IMMUNIZATION HISTORY (Pennsylvania requires the most recent date of each immunization.)

DPT Booster_____ Polio OPV Booster_____ Mumps Vaccine_____
DT_____ Measles Vaccine_____ TB Tine_____
Tetanus_____ Whooping Cough_____ Rubella_____
Hepatitis Series_____

Additional pertinent information for camp medical staff: _____

_____

_____

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_____

I have examined the person described herein and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

NAME_____ SIGNATURE _____MD

ADDRESS_____PHONE_____

_____DATE_____