



MEDICAL FORM 2017

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 _____
German Measles _____
Measles _____
Mumps _____
Rheumatic fever _____
Other _____

Eczema _____
Hay Fever _____
Poison Ivy, etc _____
Insect Stings _____
Penicillin _____
Other _____

Bed Wetting _____
Fainting _____
Hives _____
Stomach Upsets _____
Headaches _____
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 _____ Height _____ Weight _____
Glasses _____ (Circle One) Overweight Underweight Normal
Ears _____ Extremities _____
Nose _____ Posture (spine) _____
Throat _____ Skin _____
Heart _____ Physical Disability _____
Lungs _____ Emotional Disability _____
Abdomen _____ Allergies (Please specify) _____
Hernia _____
Teeth _____

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: _____

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 _____