MEDICAL FORM 2020

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 ___________

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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) ______________________________

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Chronic or Recurring Illnesses ____

Activity Restrictions ____

Recommendations (special diet, medicine, etc.) ____

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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__________________
DT__________________________
Tetanus______________________
Hepatitis Series_________________

Polio OPV Booster______________
Measles Vaccine________________
Whooping Cough_______________

Mumps Vaccine_______________
TB Tine______________________
Rubella______________________

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**__________