CAMP IROQUOINA
2341 Camp Road
Hallstead, PA 18822-9748
Phone: 570-967-2577

Health Form and Medical Release Form

Note: This form must accompany camper on registering at camp. **Do not mail in early.** If camper has been exposed to any communicable disease within three weeks immediately before coming to camp, please report this to the nurse upon arrival at camp.

To be filled in by parent/guardian of minors or by adults themselves.

Camper's Name _____ Age _____ Birth Date_____/_____/_____

Parent/Guardian _____ _____

Home Address _____

Parents Emergency Phone Numbers
Home_____
Work _____
Cell_____

Emergency Contact (**if parent/guardian cannot be reached**), notify:
Name _____ Relationship _____
Address _____ Phone Number _(_____)_____

Check – giving appropriate dates

_____ADD/ADHD
_____Athlete's Foot
_____Bed Wetting
_____Chickenpox
_____Clotting/Bleeding Disorder
_____Constipation/Diarrhea
_____Convulsions
_____Diabetes
_____Ear Trouble
_____Eating disorders
_____Eczema
_____Fainting Spells
_____Frequent Colds
_____German Measles (Rubella)
_____Heart Defect/Disease
_____Hepatitis
_____Hypertension
_____Kidney Trouble
_____Lactose intolerance
_____Measles
_____Mononucleosis
_____Mumps
_____OCD
_____Phobias (please name)
_____Rheumatic Fever
_____Stomach Upsets
_____Tuberculosis

ALLERGIES:
List all known allergies; describe the reaction and how the reaction is managed.

Medication allergies:
_____ _____
_____ _____

Food Allergies:
_____ _____
_____ _____

Other allergies (include insect stings, hay fever, asthma, animal dander, etc.):
_____ _____
_____ _____

Has camper ever been stung by a bee or wasp? _____Yes _____No

Medications List all medications, vitamins and herbals which are brought to camp. Continue on separate sheet if necessary. ***Note:*** *All medication, vitamins, and over the counter medications must be in original labeled containers with your camper's name on it.*

Medication	Dosage and Times taken each day	Reason for Taking

List any hospitalizations and surgeries (include dates and reason for admission):_____
_____
_____

List any condition for which you are currently under a physician's care:_____

Has there been a need for professional counseling? Explain._____

If a girl, has menstruation begun?_____ If not, has she been informed?_____

Has camper been out of the USA during the past year? Where? _____

Dentist/Orthodontist _____ Phone Number _(_____)_____

Physician's Name _____ Phone Number _(_____)_____

Do you carry family medical/hospital insurance? ☐ YES ☐ NO
Insurance Company_____ Policy and/or Group #_____

Insurance Company Address _____

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. **Authorization of Treatment:** In the event of an accident, injury, or sickness, I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, administer treatment and if necessary hospitalization for the above named person. I give my permission for the release of any records necessary for insurance purposes. I understand that every effort will be made to contact me; but in the event I cannot be reached, I hereby give permission to the camp director (or a responsible staff member the director appoints) to act on my behalf. I grant permission for camp medical personnel to obtain access to necessary medical, psychiatric or social work records and to receive the results of medical procedures completed while my child is enrolled at camp.

Signature of Parent/Guardian or adult camper or staff member _____ Date _____

Immunization History

Please record the date (month and year) of basic immunizations and most recent booster doses.
(Or attach a photo copy of current immunization record for camper.)

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD(tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	
MMR		_____	_____				
Or Measles		_____	_____				
Or Mumps		_____	_____				
Or Rubella		_____	_____				
Haemophilus influenza B		_____	_____	_____	_____		
Hepatitis B		_____	_____	_____			
Varicella (chicken pox)		_____	_____				

THE FOLLOWING TO BE FILLED OUT BY PHYSICIAN ONLY
IF APPLICANT IS CURRENTLY UNDER DOCTOR'S CARE OR HAS BEEN RECENTLY ILL

Health Care Recommendations by Licensed Physician:

Height_____ Weight_____ Blood Pressure_____

The applicant is under the care of a physician for the following condition(s)_____

_____

_____

Current treatment *(include current medications)*_____

_____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

_____

Does applicant have epilepsy? ☐ Yes ☐ No Does applicant have diabetes? ☐ Yes ☐ No

Recommendations and Restrictions While at Camp:

Any treatment to be continued at camp _____

_____

Any medication to be administered at camp *(specific dosages)*_____

_____

Any medically prescribed meal plan or dietary restrictions _____

_____

Any allergies *(food, drugs, plants, insects, etc...)*_____

_____

Activities to be encouraged or limited _____

_____

Additional Health Information _____

I have examined the applicant and have considered that his/her condition does, does not preclude his/her participation in an active camp program, as defined in my examination above. Date Examined _____

Physician's signature_____

Address_____ Phone_____

Number & Street *City* *Zip code* *Area Code & Number*