

2010

For Office Use

Camp Doc Reviewed

Initial

Initial

Staff

MM AH KHI KH2 WF



GENEVA GLEN CAMP Health History & Examination Form for Campers and Staff

Parents: please check session(s) MM AH KHI KH2 WF

Mail or fax this form to the address below by May 1, 2010 Geneva Glen Camp (c/o Pete LaFleur) P.O. Box 248 Indian Hills, CO 80454 phone (303) 697-4621 (x21) FAX (303) 697-9429 pete@genevaglen.org www.genevaglen.org

This Health Form is a part of the camper/staff acceptance process, and it is gathered to assist in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians of minors, or by adults (staff) themselves.

Update of the Health History is required annually. A health exam (back page) must be completed by approved licensed medical personnel, at least every year. The GG camp physician and the camp nurse will review this form and will contact the parent/guardian/staff member if there are questions or concerns. Geneva Glen reserves the right to deny enrollment for certain conditions that the camp cannot accommodate. Please be thorough and accurate in filling out this form, or it will be returned. Health form must be signed by the parent/guardian and by licensed medical personnel by the day of check-in, or enrollment will be denied. Please be sure to complete these highlighted checklist items:

GG Health Form Checklist

please notify Pete LaFleur (pete@genevaglen.org) if you anticipate delays in sending any health-form documents

- Parent/guardian complete pages 1-3
Parent/guardian sign bottom of p. 1
Be sure to include insurance carrier/plan number on p. 1
Licensed medical personnel complete and SIGN p. 4
Updated immunization records included/sent to GG (by parent or doctor)
Copy of insurance card (front and back) included

Name Last First Middle Birthdate Age at camp

Home Address Street Address City State Zip

Social Security number of participant Gender: Male Female

Custodial parent/guardian Cell Phone

Home address (if different from above) Street Address City State Zip Home Phone

Work address Street Address City State Zip Work Phone

Second parent/guardian/emergency contact Cell Phone

Home address (if different from above) Street Address City State Zip Home Phone

Work address Street Address City State Zip Work Phone

If those listed above are not available in an emergency, notify:

Name

Relationship Phones (cell/home/work)

Address Street Address City State Zip

Insurance information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name Group #

Photocopy of front and back of health insurance card must be attached to this form.

Important - Section below must be complete for attendance ** Signature required **

Parent/Guardian Authorization: This health history is correct and complete as far as I know. The person herein has permission to engage in all camp activities, except as noted.

I hereby give permission to the camp to provide routine health care and to administer prescribed medications/emergency treatment for me/my child, as may be necessary - including, but not limited to, x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting in loco parentis, if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing the protected health

information pursuant to privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide any relevant information to the camp representatives related to the individual's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization or emergent surgery, for the person named above. When needed, this completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult staff (18 and older)

Required for admission

Printed name Date

If, for religious reasons, you cannot sign this authorization, contact camp for a legal waiver that must be signed for attendance.

Cabin or Dorm

Name

Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel with the background for providing appropriate care. Keep a copy of all completed forms for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

GENERAL INFORMATION

What illnesses does your child have (e.g., asthma, seizures, behavior problems, diabetes, allergies, anaphylaxis)

Description _____

What makes it worse _____

What was the most recent episode _____

What was the worst episode _____

*** If you have a care plan for a chronic illness, please attach documentation separately.**

ALLERGIES List all known.

Describe reaction and management of the reaction.

Medication allergies (list)

Food allergies (list)

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, food allergies, etc.

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to accommodate the entire time at camp. Keep medications 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 medications on a routine basis.

This person takes medications as follows:

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

Reason for taking _____

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

Reason for taking _____

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

Reason for taking _____

Attach additional pages for more medications.

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

RESTRICTIONS

The following restrictions apply to this individual. Geneva Glen assumes your child has no dietary restrictions and – with this understanding – the camp cannot accommodate a camper with serious dietary restrictions.

Dietary (ALL dietary issues need to be discussed with camp personnel prior to camp)

Does not eat red meat

Does not eat pork

Does not eat eggs

Does not eat poultry

Does not eat seafood

Does not eat dairy products

Other (describe) _____

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary)

HEALTH QUESTIONS (explain "yes" answers below)

<i>Has/does the participant:</i>	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in past 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleep-walking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Even been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pains?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had a mental illness for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the question. Attach separate page if necessary.

IMMUNIZATIONS

** Please attach an up-to-date immunization record / summary form*

Copy of up-to-date immunization records attached to this form? Yes No

Date of last Tetanus _____

Is there anything of a confidential nature that you would like to discuss with our camp physician? (prior to camp)

Use this space to provide any additional information – about the participant’s behavior and physical, emotional, or mental health – that needs to be brought to the camp’s attention:

Name of physician for camper/staff member _____ (phone): _____

Address _____
Street Address City State Zip

Name of dentist/orthodontist for camper/staff member _____ (phone): _____

Address _____
Street Address City State Zip

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of camper or staff _____ Date _____

Patient Name: _____

Health Care Recommendations by Licensed Medical Personnel

Geneva Glen requires annual completion of camper's health history and signature below of licensed medical personnel, indicating approval of camper's medical fitness to attend camp.

Mail/fax form by May 1, 2010
Geneva Glen Camp
(c/o Pete LaFleur)
P.O. Box 248
Indian Hills, CO 80454
phone: (303) 697-4621 (x21)
fax: (303) 697-9429
pete@genevaglen.org

I examined this individual on _____ (date).

BP _____ Weight _____ Height _____

In my opinion, the above applicant is able to participate in an active camp program. State yes, or no: _____

Recommendations and Restrictions at Camp

Description of any chronic illnesses, including mental health, that could be a problem at camp:

Medications / treatments to be administered at camp (name, dosage, frequency):

Any medically-prescribed dietary restrictions:

Known allergies (Geneva Glen cannot accept campers with dietary restrictions, unless they are capable of making their own selections from the nutritionally balanced meals provided by camp):

Description of any limitations or restriction on camp activity:

Additional information for health care staff at the camp:

Signature of Licensed Medical Personnel

MD, DO, Nurse Practitioner, Physician Assistant

Printed Name _____ Title / Degree _____

Address _____

Phone _____ Date _____

For camp use only:

Screening Record

Screened within 24 hours of arrival and found to pass

Problems found (list) _____

Updates/additions to health history notes Yes No None required

Current health needs identified _____

Observational Notes _____

Screened by _____ Date Screened _____