2012

For Office Use

Camp Doc Reviewed

Initial

☐ Staff

☐ MM ☐ AH ☐ KHI ☐ KH2 ☐ WF

GENEVA GLEN CAMP

Health History & Examination Form for Campers and Staff

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

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.

Mail this form to the address below by **May 1, 2012**
Geneva Glen Camp • P.O. Box 248 • Indian Hills, CO 80454
Questions can directed to Johnny Domenico at:
phone (303) 697-4621 (x13) • **FAX** (303) 697-9429
johnny@genevaglen.org • www.genevaglen.org
faxed forms also should be mailed for clarity
(if you are not able to send page 4 by May 1, please send 1-3 & note when we can expect p. 4)

Updates of Health History (pp. 1-3) and p. 4 medical recommendation are required **annually**. Per American Camp Association guidelines, the certified health exam must be within the previous 24 months from the time that the camper attends Geneva Glen (**it is the parent/guardian's responsibility to clarify with your medical provider, well in advance, what they require in order to complete p. 4**). 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 form, or it will be returned. Health Form must be signed by parent/guardian (p. 1) and by licensed medical personnel (p. 4) by day of check-in, or enrollment will be denied.

Cabin or Dorm ______

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 participant covered by family medical/hospital insurance? ☐ Yes ☐ No Group # ______

If so, indicate carrier or plan name ______

▶ **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 Geneva Glen to arrange related transportation. I agree to the release of any records that are 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 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 disclosure to camp representatives of the protected health information of the person who is 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 that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and to 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** ______

Name ______

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

Health History: This information must be filled in by the parent/guardian/adult 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 prior to or upon the participant's arrival at camp. Provide complete information so that the camp can be aware of your needs.

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

Has your child ever been hospitalized? (provide details; attach additional sheet if needed)

___

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 ___

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. **Geneva Glen accepts only original containers.** Keep medications in the original packaging/bottle that identifies: 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, that have been prescribed by an MD or DO.

Note: Geneva Glen routinely provides the following medications (no need to send with your camper): Acetaminophen, Ibuprofen, Tylenol, Benadryl, Zyrtec, Claritin, antacid and cough medicine.

☐ This person takes medications as follows: *Attach additional pages for more medications*

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 ___

Identify any medications taken during the school year that the 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 medical 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)

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

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

Signature of camper or staff ______________________________ Date ______________

Parents Health Form Checklist (be sure you have completed these steps)

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

please notify Johnny Domenico (johnny@genevaglen.org) if you anticipate delays sending any health-form documents

Patient Name ______________________________

Mail/fax form by May 1, 2012
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Health Care Recommendations by Licensed Medical Personnel

Geneva Glen requires an **annual** *completion of a camper's health history and signature below of licensed medical personnel, indicating approval of the camper's medical fitness to attend camp. Per American Camp Association guidelines, the certified health exam must be within the previous 24 months from the time that the camper attends Geneva Glen.*
Note: It is the parent/guardian's responsibility to clarify with your medical provider, well in advance, what conditions and time frame they specifically require in order to complete/certify this page.

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)

Note – Geneva Glen cannot accept campers with dietary restrictions, unless they are capable of making their own food selections from the nutritionally-balanced meals provided by camp.

Any medically-prescribed dietary restrictions

Known allergies

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 ____________________

This box for camp use only (below):
Additional Comments