

# 2010 CAMP ANOKIJIG HEALTH & MEDICAL FORM

**Health History: (Pages 1-3)**  
**Filled out by Parents/Guardians Each Year**

**Physical Examination: (Page 4)**  
**Filled out by Licensed Medical Personnel**

The information on this form is gathered to assist us in identifying appropriate care and adhere to state recommendation. Health history (first 3 pages) must be filled out by the parents/guardians of minors or by adults themselves. A new Health & Medical Form required annually (pages 1-3). Physical exams (page 4) must be completed by a licensed medical personnel at least every two years.

<b>DOES CAMPER NEED A NEW DOCTOR'S PHYSICAL EXAM FOR CAMP ANOKIJIG?:</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> If "NO" parent/guardian must complete pages 1 - 3 annually If "YES" parent/guardian must complete pages 1 - 3 annually plus camper must get a physical examination – see page 4
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**Health History (Filled out by Parents/Guardians):**

**Camper Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
(Last, First & Middle Initial)

**Home Address:** \_\_\_\_\_  
Street City State Zip

**Custodial Parent/Guardian Name:** \_\_\_\_\_

**Daytime Phone:** \_\_\_\_\_ **Evening Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
(If different) Street City State Zip

**Business Address:** \_\_\_\_\_  
Street City State Zip

**If Not Available in an Emergency, Notify:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street City State Zip

Bills for Medical visits and prescriptions will be mailed to home address above unless box checked, complete insurance information is supplied, and insurance card is provided : <input type="checkbox"/> Bill me at home address <input type="checkbox"/> Insurance card and all information attached
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**IMPORTANT:**

PARENT/GUARDIAN'S RELEASE AND AUTHORIZATION FOR TREATMENT MUST BE COMPLETE AS STATED

**PARENT/GUARDIAN'S RELEASE AND AUTHORIZATION FOR TREATMENT**

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

**Authorization for Treatment:**

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, administration of over the counter medicine, and 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 purposed.

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 protected health information pursuant to the 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) in the case of minors, to provide relevant information to the camp representatives related to the person'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. I understand the Friends of Camp Anokijig and Camp Anokijig does not cover camper health and medical expenses.

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, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staff: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

**COMPLETED BY PARENT/GUARDIANS ANNUALLY**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

MI: \_\_\_\_\_

SESSION 1 2 3 4 5 6 7 8 9

Camper Name: \_\_\_\_\_

**Heath History (Filled out by Parents/Guardians):**

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 the background to provide appropriate care. Keep a copy of the completed form 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.

**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, etc.

_____	_____
_____	_____

**Medications Being Taken**

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the camper, 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 regular medications as follows (prescription medications will be given as labeled by the Doctor)

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: \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Camper Name: \_\_\_\_\_

**General Questions** (Explain "yes" answers below)

Has/does the participant:	Yes	No	Yes	No
1. Had any recent injury, illness or infectious disease? .....	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)? .....	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition? .....	<input type="checkbox"/>	<input type="checkbox"/>	18. Bringing an orthodontic appliance to camp? .....	<input type="checkbox"/>
3. Ever been hospitalized? .....	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin conditions (e.g., itching, rash, acne)? .....	<input type="checkbox"/>
4. Ever had surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes? .....	<input type="checkbox"/>
5. Have frequent headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma? .....	<input type="checkbox"/>
6. Ever had a head injury? .....	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months? .....	<input type="checkbox"/>
7. Ever been knocked unconscious? .....	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation? .....	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear? .....	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking? .....	<input type="checkbox"/>
9. Ever had frequent ear infections? .....	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have experienced first menstrual cycle.....	<input type="checkbox"/>
10. Ever passed out during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>	26. If female, have an abnormal menstrual history? .....	<input type="checkbox"/>
11. Ever been dizzy during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>	27. Have a history of bed-wetting? .....	<input type="checkbox"/>
12. Ever had seizures? .....	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had an eating disorder? .....	<input type="checkbox"/>
13. Ever had chest pain during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>	29. Ever had emotional difficulties for which professional help was sought? .....	<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"/>		
16. Ever had back problems? .....	<input type="checkbox"/>	<input type="checkbox"/>		

Please explain any "yes" answers, noting the number of the questions.

Which of the following Has the participant had?	Year	Please give all dates of immunization for: Vaccine:	Date: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Measles	_____	DTP	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Chicken Pox	_____	TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German Measles	_____	Tetanus	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	_____	Polio	_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	_____	MMR	_____	_____					
<input type="checkbox"/> Hepatitis B	_____	Or Measles	_____	_____					
<input type="checkbox"/> Hepatitis C	_____	Or Mumps	_____	_____					
<input type="checkbox"/> Pertussis (whooping cough)	_____	Or Rubella	_____	_____					
		Haemophilus Influenza B	_____	_____	_____	_____			
		Hepatitis B	_____	_____	_____				
		Varicella (chicken pox)	_____	_____					

**Remember to send copy of Insurance Card**

Use this space to provide any additional information about the participant's behavior and physical, emotional. Or mental health about which the camp should be aware.

Camper Name: \_\_\_\_\_

ACA-accreditation requires exams within 24 months of last date of camp attendance to be filled out by a licensed M.D., R.N., or Equivalent. Each camper must have a physical exam on file in order to attend camp.

### Physical Examination by Licensed Medical Personnel

Date of Exam: \_\_\_\_\_.

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant:  is able to participate in active camp program activities with no restrictions  
 is able to participate in an active camp program with the restrictions indicated below.

The applicant is under the care of a physician for the following conditions

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Recommendations and Restrictions at Camp

Treatment to be continued at camp \_\_\_\_\_

\_\_\_\_\_

Medications to be administered at camp (name, dosage, frequency) \_\_\_\_\_

\_\_\_\_\_

Any medically-prescribed meal plan or dietary restrictions \_\_\_\_\_

\_\_\_\_\_

Known allergies \_\_\_\_\_

\_\_\_\_\_

Description of any limitation or restriction on camp activities \_\_\_\_\_

\_\_\_\_\_

Additional information for health care staff at the camp \_\_\_\_\_

\_\_\_\_\_

**Signature of Licensed Medical Personnel** \_\_\_\_\_

Printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

#### Mailing Address:

Camp Anokijig  
W5639 Anokijig Lane  
Plymouth, WI 53073  
920-893-0782  
800-741-6931