

# Camper Health History Form

**CAMP OLIVER**

PO BOX 206 DESCANSO, CA 91916

Camper Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
(Last) (First) (Initial)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian 1: Name: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Parent/Guardian 2: Name: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**Medical Information:**

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_ Policy and/or Group#: \_\_\_\_\_

**Medical Information past or present (please check).**

Currently under Dr. care	<input type="checkbox"/> Yes <input type="checkbox"/> No	ADD/ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Defect/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head Lice (recent)	<input type="checkbox"/> Yes <input type="checkbox"/> No	German Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent Hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bedwetting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Diseases or Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleepwalking	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

For each Yes, Please explain: \_\_\_\_\_

**Allergies:**

Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bee Stings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Poison Oak/Ivy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bee Sting Kit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foods	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other insects or animals	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Dietary Restrictions? Yes No \_\_\_\_\_

Any reason to restrict full activity including swimming, long hikes, strenuous physical games?: Yes No \_\_\_\_\_

If Yes, please explain: \_\_\_\_\_

**Medication:** This section should be filled out for all medications to be taken at camp. Please note if medication is taken on *as needed basis*. (attach additional page if necessary)

	Name of Medication	Dosage/Route	Number of times/day	Reason
1.				
2.				
3.				
4.				
5.				

**Non-Prescription Medications:** I authorize the following medications to be administered if deemed necessary:

Tylenol <input type="checkbox"/> Yes <input type="checkbox"/> No	Benadryl <input type="checkbox"/> Yes <input type="checkbox"/> No	Pepto Bismol <input type="checkbox"/> Yes <input type="checkbox"/> No	Cough Syrup/Drops <input type="checkbox"/> Yes <input type="checkbox"/> No
Ibuprofen <input type="checkbox"/> Yes <input type="checkbox"/> No	Decongestant <input type="checkbox"/> Yes <input type="checkbox"/> No	Milk of Magnesia <input type="checkbox"/> Yes <input type="checkbox"/> No	Calamine Lotion/Cortaid <input type="checkbox"/> Yes <input type="checkbox"/> No

**AUTHORIZATION OF CONSENT FOR TREATMENT OF A MINOR:** The following MUST be completed.

(I) (We), the undersigned, parent(s) of \_\_\_\_\_, a minor, do hereby authorize the staff of Camp Oliver, as agent(s) for the undersigned, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the California Medicine Practice Act on the medical staff of a licensed hospital, whether such examination, diagnosis or treatment is rendered at the office of said physician or at such a hospital.

It is understood that this authorization is given in advance of any specific examination, diagnosis, treatment or hospital care being required, and is given to provide authority and power on the part of our above-named agent(s) to give specific consent to any and all such examinations, diagnoses, treatments or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. This authorization is give pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective until Camp Oliver receives written notification from you canceling this consent form.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

# Health Examination to be completed by Licensed Medical Personnel

**Note:** We require a Health Exam by licensed medical personnel within 24 months of camp attendance. If your child has had a health exam within the last 24 months, please attach the signed and dated copy here.

Child's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

We ask for your written authorization prior to the child's attendance at Camp Oliver. Please realize that camp is held at over 3400 feet elevation and the programs are very active. We have strenuous hiking, games, swimming and camp activities. Your careful consideration is appreciated.

I have examined the child named on this form within the past two years. Date of Exam: \_\_\_\_\_

After examination and my review of his/her health history, it is my opinion that this person is physically able to engage in camp activities, except as noted below.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Is the applicant under the care of a physician for any conditions?  Yes  No Please explain: \_\_\_\_\_

Are there any restrictions in any of the physical programs (hiking, swimming, games, etc.)? \_\_\_\_\_

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

Any treatment or medications to be continued at camp (Please give specific dosages): \_\_\_\_\_

Any Allergies? (Food, drugs, plants, insects, etc): \_\_\_\_\_

Additional health information for camp staff: \_\_\_\_\_

<b>Immunization History:</b> Please give the date of immunization.			
Tetanus _____	Polio _____	Mumps _____	Rubella _____
Diphtheria _____	Chicken Pox _____	Measles _____	Other _____

**Licensed Medical Personnel Signature:** \_\_\_\_\_

**Printed:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_