Health History and Examination Form

For Children, Youth and Adults Attending LGP National Camp. The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history must be fill out by parents/guardians of minors or by adults themselves. Update required annually. Health exam is recommended but not required. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of this 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 child's needs.

Name _______________________________ Birthdate __________________ Age of Camper _________
Home Address ____
Custodial parent/guardian ____
Parent e-mail ____ Phone _____________________________
Cell phone ______________________________ Daytime Phone __________________________________
Address ____

INSURANCE INFORMATION - please attach copy of insurance card (front and back)
Is the participant covered by family medical/hospital insurance? Yes _______ No ________
Policy holder name __________________________________ Carrier _____________________________
Group # ________________________________
ALLERGIES (List all known) Describe reaction and management of the reaction
____ Allergy to Latex _____
____ Allergy to adhesive _____
MEDICATION ALLERGIES
(LIST)____
____

FOOD ALLERGIES (LIST)
____
IS CAMPER CURRENT ON ALL IMMUNIZATIONS? YES ________ NO _______ **Please attach immunization list**

MEDICATIONS BEING TAKEN
This person takes **NO** medication on a routine basis _______ **X if this applies**
Bring list of all prescription and over the counter medications that your child routinely takes. Bring enough medication to last the entire time at camp. Keep all medications in original packaging/bottles. Medication name, dosage (amount/frequency) prescribing physician should be listed on the packaging.
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 as needed. 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.

DIETARY

____

ACTIVITY

____

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

OVER THE COUNTER MEDICATIONS

If your child needs over the counter (OTC) medications while at camp the nurses will have these available. Please indicate if your child may be administered these medications by checking the boxes below. We will administer these per packaging directions.
Comment if needed.

Pain/First Aid **Comment**

____ Tylenol ____

____ Ibuprofen ____

____ Visine (eye drops) ____

____ Saline (eye flush) ____

____ Hydrocortisone Cream ____

____ Benadryl Cream ____

____ Betadine ____

____ Hydrogen Peroxide ____

____ Neosporin
____
____ Cough drops
____
____ Tums
____

Allergy
____ Benadryl
____
____ Zyrtec
____
____ Claritin
____

HEALTH HISTORY AND EXAMINATION FORM
GENERAL QUESTIONS: Yes or No (Explain "yes" answer below)
YES NO 1. Had a recent injury, illness or infectious diseases? Explain ________________________________

____
____
YES NO 2. Have a chronic or recurring illness/ condition? Explain _____________________________________

____
____
YES NO 3. Have problems with sleepwalking? Explain ____

____
_

YES NO 4. If female, does she have an abnormal menstrual period? Explain ___________________________

____

YES NO 5. Have a history of bedwetting? Explain ____

____

YES NO 6. Ever had an eating disorder? Explain ____

____

YES NO 7. Ever had emotional difficulties? Explain ____

____

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 ____

Name of family physician ____ Phone _______________________________

Address ____

Name of family dentist/orthodontist ________________________________ Phone _______________________________

Address ____

PHOTOCOPY OF FRONT AND BACK OF HEALTH INSURANCE CARD MUST BE ATTACHED TO THIS FORM
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. I hereby give permission to the camp to provide, seek 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 for insurance purposes. In the event I, or the emergency contact, cannot be reached in an emergency, I hereby give permission to the Camp Director or his/her designee, to act as the parent/guardian concerning the health and welfare of the participant. Further, it is my intention that the appropriate representative 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 and 164.510 (b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (I) 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. 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 ____ Date
____

Please print out form, fill out, and mail to Jill Jahn LGP Camp, 28851 Morning Glory Lane, New Prague, MN 56071