Camp Netimus Medical Packet-Camper

Parents: please complete pages 1 through 3 of this packet. A physician must complete the Camp Netimus Medical Form (page 4). If there are any medications or injections that must be given during camp, your physician must send specific written directions on the form and indicate any non-prescription medications the camper may need. **Only when all 4 pages are completed, signed and received in the camp office will the camper be able to participate in sports activities.**

Camper's Name: ____ Age at Camp: _______ Date of Birth: ____________
Last First Middle month/day/year

Gender: ____ Female ____ Male

If we admit your child to the Health Care Center after midnight in a non-emergency situation, do you prefer to be called regardless of the time? Please circle: yes no_____

Custodial Parent/Guardian ____________________________________ Relationship to camper: ____________________

Address: ______________________________ City: ____________________ State/Country ________Zip: _____________

Home Phone: ________________________ Cell Phone: ______________________ Work Phone: ____________________

E-mail: ____

Second parent, guardian, or emergency contact: ______________________ Relationship to camper: ____________________

Address: ______________________________ City: ____________________ State/Country ________Zip: _____________

Home Phone: ________________________ Cell Phone: ______________________ Work Phone: ____________________

E-mail: ____

Additional emergency contact: _________________________________ Relationship to camper: _____________________

Address: ______________________________ City: ____________________ State/Country ________Zip: _____________

Home Phone: ________________________ Cell Phone: ______________________ Work Phone: ____________________

E-mail: ____

Vacation Information while your child is at camp: Please fill out this form or attach your travel itinerary.

Dates out of town: ______________Vacation location: ______________________ Contact phone number: ________________

Dates out of town: ______________Vacation location: ______________________ Contact phone number: ________________

Camper's Physician: ___________________________Address: _________________________ Phone: ________________

Camper's Dentist: _____________________________Address: _________________________ Phone: ________________

Camper's Orthodontist: _________________________Address: _________________________ Phone: ________________

Other Doctor (specify): _________________________Address: _________________________Phone: ________________

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of custodial parent/guardian: ______________________________ Date: ______________

Print your name please: ____

Camper's Name: _____________________________________ Date: ___________

Last First

1. Are there any allergies?

Allergic to:	NO	YES	LIST known allergies and describe allergic reaction
Medications			
Food			
Bee Stings			
Other			

Are any specific medications required to address any of these allergic reactions? **See note at bottom of page.*

2. Restrictions:
   - ☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
   - ☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. (Describe below)

3. Please list and describe any dietary restrictions or issues.

4. Has your daughter menstruated? Y / N If yes, date of first period________Are her periods regular? Y / N

   If no, has she been told about menstruation? Y / N

5. If your child has any of the following health issues at home what is your usual remedy?
   A. Nosebleeds

   B. Cold symptoms/allergy symptoms

   C. Menstrual cramps

   D. Head lice; how was she treated and/or with what product(s)?

   Please contact the office if your child contracts head lice anytime after March 31.

6. Medication: ☐ This camper will not take any daily medications while attending camp.
   ☐ This camper will take the following daily medications while attending camp.

Medication	Date started	Reason for taking it	When it is given (circle)	Dosage	How it is taken
			Breakfast Lunch Dinner Bedtime Other		
			Breakfast Lunch Dinner Bedtime Other		
			Breakfast Lunch Dinner Bedtime Other		

*All prescriptions/over the counter medications must be in their original container labeled with the camper's name, name of medication, strength of medication, and dosage. It is the parent's responsibility to provide sufficient medication for the child's entire length of stay. Campers **may not** keep medication in their cabins except for asthma inhalers. Please send 2 canisters. All medications must be turned over to the camp medical staff for administration.

Camper's Name: ______________________________ **Date:** ___________

Last First

Please Attach Recent Photo of Camper Here

General, Mental, Emotional, and Social Health History

Check "Yes" or "No" for each statement.

Has/does the camper…

1. Ever been hospitalized?........................ ☐ Yes ☐ No
2. Ever had surgery?........................ ☐ Yes ☐ No
3. Have recurrent/chronic illnesses? .... ☐ Yes ☐ No
4. Had a recent infectious disease?........................ ☐ Yes ☐ No
5. Had a recent injury? .... ☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath?........................ ☐ Yes ☐ No
7. Have diabetes?........................ ☐ Yes ☐ No
8. Had seizures?........................ ☐ Yes ☐ No
9. Had headaches? .... ☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear?........................ ☐ Yes ☐ No
11. Had fainting or dizziness? .... ☐ Yes ☐ No
12. Passed out/had chest pain during exercise? .... ☐ Yes ☐ No
13. Had mononucleosis ("mono") during the past 12 months?........................ ☐ Yes ☐ No
14. If female, have problems with periods/menstruation?........................ ☐ Yes ☐ No
15. Have problems with falling asleep/sleepwalking? .... ☐ Yes ☐ No
16. Ever had back/joint problems? .... ☐ Yes ☐ No
17. Have a history of bedwetting?........................ ☐ Yes ☐ No
18. Have problems with diarrhea/constipation? .... ☐ Yes ☐ No
19. Have any skin problems?........................ ☐ Yes ☐ No
20. Traveled outside the country in the past 9 months? .... ☐ Yes ☐ No
21. Ever been treated for attention deficit disorder(ADD) or attention deficit/hyperactivity disorder(ADHD)☐ Yes ☐ No
22. Ever been treated for emotional or behavioral difficulties or an eating disorder? .... ☐ Yes ☐ No
23. During the past 12 months, seen a professional to address mental/emotional health concerns?............. ☐ Yes ☐ No
24. Had a significant life event that continues to affect the camper's life?........................ ☐ Yes ☐ No

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others

Please explain "Yes" answers on a separate page, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel. Attach additional information if needed.

Did we forget to ask something? Please provide information on a separate page and attach to the camper medical.

BE SURE TO INCLUDE A *COPY OF BOTH SIDES OF YOUR HEALTH INSURANCE CARD*.
IN THE EVENT IT IS NECESSARY TO BRING YOUR CHILD TO THE HOSPITAL, THE HOSPITAL WILL REQUIRE A COPY OF HEALTH INSURANCE CARD.

Name of person insurance is enrolled under: ______________________________

Social Security Number: _______ _______ ________ **Date of Birth:** ______________________

Name of Employer: ______________________________

Address of Employer: ______________________________

Street City State/Country Zip

Insurance Company: ______________________ Phone Number: ______________________

Address: ______________________________

Street City State/Country Zip

Policy Number: ______________________ **Group Number:** ______________________

Camp Netimus Medical Form-Report by Licensed Health Care Provider

Camper's Name: ______________________________ **Date of Birth:** ______________ **Date of Examination:** ______________
Last First

Camper's Height ________ **Weight** __________ **Blood Pressure** ________

Immunization History-Immunizations must be up to date

Vaccines	*Date of Initial Series*	*Booster Date*
DPT/TD/Td		
HIB		
Measles/Mumps/Rubella		
Varicella (Chicken Pox)		
Polio		
Hepatitis A		
Hepatitis B		
TETANUS-must have date		
Meningitis		

Indicate any current treatments and medications to be given at camp. Specify dosage and frequency.

Are there any play or physical restrictions? Please specify.

Are there any dietary restrictions?

Additional health recommendations-be specific:

Health History

Condition	*Check & give approx. dates*
Frequent ear infections	
Heart defects or disease	
Seizures	
Diabetes	
Bleeding or clotting disorders	
Hypertension	
Chicken pox	
Other-Please list	
Allergies	***Specify as necessary***
Food	
Drugs	
Allergic Rhinitis	
Asthma	
Insect stings (systemic reaction)	
Other	

Does camper wear an orthodontic appliance? _____yes _______no

Does camper wear glasses or contacts? _____ no
_____ glasses _____ contacts

Does camper wear prosthesis or any other type of appliance?
_____no _____ yes, please explain: ______________________

I have examined the above applicant on the date indicated. In my opinion, the above applicant's condition does not preclude her from participation in an active camp program.

Licensed Provider's Signature ______________________
Print name of Provider ______________________
Address ______________________
Phone ______________________