Cedarbrook Camp Southern California **BRING WITH YOU**

HEALTH HISTORY/EXAMINATION FORM **TO CAMP**

TO BE FILLED IN BY CAMPER'S PARENT/GUARDIAN, STAFF MEMBER, OR ADULT CAMPER

Name _____ Date of Birth ___/___/___ Age ____ Sex ____
Last First MI

Address _____ Work/Cell Phone (____)_____
Number/Street City State Zip

Email address _____@_____

Parent/Guardian/Spouse's Name _____ Home Phone (____)_____
Last First

Address _____ Work/Cell Phone (____)_____
Number/Street City State Zip

In emergency, if above is not available, contact:

Name _____ Home Phone (____)_____
Last First Relationship

Address _____ Work/Cell Phone (____)_____
Number/Street City State Zip

OR

Name _____ Home Phone (____)_____
Last First Relationship

Address _____ Work/Cell Phone (____)_____
Number/Street City State Zip

Family Physician _____ Phone (____)_____

Family Dentist _____ Phone (____)_____

Medical/Hospital Insurance _____ Policy/Group # _____

Name on Policy _____ Relationship _____

CURRENT MEDICATION

Medication & Strength	How Many Taken	When Taken	Reason for Taking

NOTE: ALL medication brought to camp, including prescription, over the counter, vitamins, and herbal remedies, **MUST** be in original containers showing the name of the medication, the correct dosage, and the user's name printed on the label.

AUTHORIZATION FOR TREATMENT

If not completed, person named above may not stay at camp. 4 Initials and a signature.

The health history on the back is correct so far as I know. _____
The person herein described has permission to engage in all prescribed activities except as noted on the reverse side. _____
I hereby give permission to the camp nurse to give over-the-counter medications to my child as deemed necessary. _____
I hereby give permission to the medical personnel selected by the camp director to provide routine health care: to administer medications, to order x-rays, routine test, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/my child. I also hereby give permission for the nurse to share with camp staff information contained on the health form, as appropriate. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director 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/Guardian/Adult Staff Member _____ Date ____/____/____

HEALTH HISTORY: Has camper/staff member had? If so, give approximate dates.

Bleeding/clotting disorder		Heart Problems		Measles/Rubeola	
Diabetes		High Blood Pressure		German Measles/ Rubella	
Frequent Ear Infections		Frequent Fainting		Mumps	
Epilepsy/Seizures		Chicken Pox		Asthma	
Disability		Chronic Illness			
Surgeries					

ALLERGIES: Please be specific about type and reactions

Seasonal/Hay Fever	Type	Reaction	Food Allergies	Type	Reaction
Insect Stings	Type	Reaction	Food Intolerance	Type	Reaction
Medications	Type	Reaction	Other	Type	Reaction

FEMALES: Menstruation: Started? Yes___ No ___ Regular? Yes___ No___ Date of last cycle ____/____/____;
Menopausal _____ If not started yet, has she been told about it? Yes ____ No ____

IMMUNIZATIONS: Please give last month and year of immunization or booster

DTP series	/	Mumps	/	Tuberculin test	/
Measles	/	Polio	/	BCG	/
Rubella	/	Tetanus	/	Meningococcal	/
Pneumococcal	/	Influenza	/	Shingles	/

Health Examination (Examination by an MD, NP, or PA recommended but not required.)

I have examined the applicant on ____/____/____ and reviewed the health history and believe it to be correct ____

*Does applicant have any conditions which limit participating in swimming, hill climbing, team sports, and other strenuous activities? Yes____ No ____

*If yes, specify which camp activities in which applicant may not participate. _____

_____

*Treatment that needs to be continued at camp, besides medications previously mentioned. _____

_____

_____ _____ Date ___/___/___
Examiner's Signature Examiner's Printed Name and Title

Phone (____)_____ Address _____
Number/Street City State Zip

If applicant not examined by an MD, NP, or PA, starred questions must be answered by parent/guardian/adult camper and signed by the same.

Signature _____ Parent Guardian Self Date ____/____/____
Circle One

Revised 7/2016