

Health History and Examination Form

All campers must undergo a complete physical exam within the past 24 month period. On the opposite year you are required to take this form to your doctor and have them fill in the date examined, any medical changes and sign the bottom of the form in the appropriate space. We no longer accept medical forms from previous years! Please **RETURN THIS FORM TO: Att: Camp Jordan, Bangor Y, 127 Hammond St. Bangor, ME. 04401**

Name _____

Birthdate _____ Sex _____ Age _____

Parent/Guardian _____

HomeAddress _____ Tel# _____

BusinessAddress _____ Tel# _____

Emergency Contact _____ Tel# _____

Emergency Contact Address _____ Tel# _____

Emergency Contact Business _____ Tel# _____

If not available in an emergency, notify

Name _____

Telephone #: _____

Address _____

Operations or serious injuries (dates) _____

Chronic or recurring illness or medical condition, including

allergies _____

Dietary restriction _____

Current medications (send instructions) _____

Other disease _____

Name of dentist/orthodontist _____ Tel# _____

Name of Family physician _____ Tel# _____

Do you carry family medical/hospital insurance? Yes No

If so, indicate: Carrier _____ Policy or group # _____

Suggestions on health related information for camp personnel _____

Health History

(Check, give approximate dates).

_____ Frequent Ear Infections

_____ Heart Defect/Disease

_____ Convulsions

_____ Diabetes

_____ Bleeding/Clotting **Disorders**

_____ Hypertension

_____ Mononucleosis

_____ Asthma

Diseases

_____ Chicken Pox

_____ Measles

_____ German measles

_____ Mumps

Allergies (Dates not needed)

_____ Hay Fever

_____ Ivy Poisoning, etc.

_____ Insect Stings

_____ Penicillin

_____ Other (specify)

For Females: Has this person menstruated? Yes / No

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. 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 or adult camper/staff _____

Witness _____ Date ____ / ____ / ____

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor or adult camper/staff _____ Date ____ / ____ / ____

Please See Other Side!

Parent Permission Form
Approval for Self – Administered Emergency Medication

As the parent or guardian of _____,
Camper Name

During his/her time at camp, the above listed camper is permitted to have readily available (carry or possess outside of regular supervision of the camp’s health staff) and self administer as medically necessary:
(Circle all that apply or list other EMERGENCY SELF – MEDICATION device.)

1. Asthma Inhaler
2. Epinephrine Pen
3. Other _____

I have read the State Of Maine Law below, and confirm that the camper has the knowledge and the skills to have readily available and safely self administer the indicated emergency medication in camp.

Parent or Guardian Signature

Date

Summary of Maine Law of Self Administration of Emergency Medications

Recreational camps for children; emergency medication. A recreations camp for boys and girls must have a written policy authorizing campers to self administer emergency medication, including but not limited to, an asthma inhaler or and epinephrine pen. The written policy must include the following requirements:

- A. A camper who self – administers emergency medication must has prior written approval of the camper’s primary health care provider and the camper’s parent or guardian.
- B. The camper’s parent or guardian must submit written verification tot he camp from the camper’s primary health care provider confirming that the camper has the knowledge and the skills to safely self administer the emergency medication in camp.
- C. The camp health staff must evaluate the campers technique to ensure proper and effective use of the emergency medication in camp ; and
- D. The emergency medication must be readily available to the camper.

The full statute may be viewed at: <http://janus.state.me.us/legis/statutes/22/title22sec2496.html>

Immunization History

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria	1	1
Pertussis (Whooping Cough)	2	2
Tetanus <i>(DPT)</i>	3	
Tetanus Diphtheria <i>(TD)</i>		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, rubella)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin Test (most recent)		
Hemophilus influenza b (HIB)		
Hepatitis B		

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant. Date Examined _____

In my opinion, the above's condition does does not preclude his/her participation in an active camp program.

Height _____ Weight _____ Blood Pressure _____

The applicant is under the care of a physician for the following condition(s). _____

Current treatment (include current medications) _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Does applicant have epilepsy? Yes No

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp _____

Any medication to be administered at camp (specific dosages) _____

Any medically-prescribed meal plan or dietary restrictions _____

Any allergies (food, drugs, plants, insects, etc.) _____

Activities to be encouraged or limited _____

Additional health information _____

Please See Other Side!

Licensed Physician's Signature: _____

Address: _____ **Phone:** _____

Date of Form Completion: _____ **By:** _____

