

Camp Cherith® Health History and Physical Exam

This form must be filled out completely and signed by parent/guardian prior to arrival at camp. A medical examination is strongly encouraged. **A Physician's signature is required for anyone on prescription medications.** (See reverse side.) When a camper is ill or injured, Camp Cherith will call and inform parents of camper's status as necessary.

Parents will be billed for any **illness** necessitating medical intervention. **Camp Cherith** will be responsible for covering the costs of any **injuries** requiring medical intervention.

Camper's Name _____ Birth date _____ Age _____
Last First Middle Initial

Parent/Guardian _____

Home Phone (____) _____ Parent/Guardian Cell phone (s) _____

Home Address _____
Street Address City State Zipcode

If not available in emergency, notify:

1. Name _____ Phone (____) _____ Cell _____

Address _____

2. Name _____ Phone (____) _____ Cell _____

Address _____

Name of Insurance Company/Medical Plan _____

(Photocopies of Insurance and Pharmacy Cards are helpful and can be attached to this form)

Policy Number/Group/ID _____

Prescription number (example—Bin #, PCN #, Group #, ID #, RXGP #, etc.) _____

Insurance Holder's Name and Birthdate _____

Name of Home Clinic _____ Name of Doctor/Phone _____

Health History

Yes No

- ___ ___ Asthma-Explain severity _____
- ___ ___ Appendicitis
- ___ ___ Bleeding Disorder
- ___ ___ **Chicken Pox** **Vaccine**
- ___ ___ Diabetes-Explain _____
- ___ ___ Epilepsy
- ___ ___ Hay Fever
- ___ ___ Hepatitis
- ___ ___ High Blood pressure
- ___ ___ Migraine Headache
- ___ ___ Nervous Stomach
- ___ ___ Seizure Disorder
- ___ ___ Sinus Trouble
- ___ ___ Suicide Attempt

Yes No

___ ___ Thyroid Overactive/Underactive

___ ___ Heart Problem

Explain _____

Ears:

___ ___ Frequent infections

___ ___ General hearing problem

___ ___ Wears hearing aid

Eyes:

___ ___ Glasses

___ ___ Contact lenses

Height _____

Weight _____

Immunizations up to date Yes No

If No, explain _____

Date of last Tetanus shot _____

Girls: Has menstrual period begun? Yes No If not, has she been told about it? Yes No Cramps? Yes No

Allergies-Food, Insects, Drug (specify): _____

Surgerie or Serious Injuries (dates): _____

Chronic or recurring illness: _____

Any current physical, mental, or psychological conditions that require medications, treatment, or special restrictions or considerations while at camp? _____

Prescribed Medication (Dr. signature required on reverse side of form, medication must be labeled and in original container) _____

Current over-the-counter medications (give name and reason for taking) Are medications being sent with child to camp? yes

Camp Cherith has a supply of basic pain relief, cold, and cough medicine.
(over)

Parent's Authorization

To the best of my knowledge all information provided by me is correct, accurate and complete. The person herein described has my full permission to participate in camp activities except as indicated. In the event of illness or injury in the course of such activity, I give my permission for routine medical care and administration of medication both prescription and over the counter. I give permission for medical measures to be instituted without delay as the judgment of medical personnel dictates. I give permission to release any records necessary for insurance purposes directly to Camp Cherith.

Parent/Guardian (signature required) _____ Date _____

**Medical Provider's Instructions/Signature
(required only if on prescription medication)**

Recommendations & restrictions while at camp:

Special Diet _____

Strenuous Activity _____

Water Activity _____

Other _____

Prescribed Medication (name, dosage, and reason for taking) _____

(Medical Provider's Signature & Title)

(_____) _____
Phone Number Date

Exam not required. You may just bring health form to your clinic for instructions/signature of prescripion medication provider.