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 OveractivelUnderactive
___ ___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
_____

Updated 2/2016

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 prescripton medication provider.

Updated 2/2016