

# Health Form

**THIS FORM MUST BE COMPLETELY FILLED OUT AND RETURNED *WITH REGISTRATION FORM***

**\*\*NOTE: This form does not have to be filled out or signed by a doctor.**

Camper  Staff Name \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_ Sex: M F  
 Home Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip Code \_\_\_\_\_  
 Parent(s)/Guardian(s) Name \_\_\_\_\_ email: \_\_\_\_\_  
 Phone# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

**If Parents are not available in an emergency notify:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

**Camp Sankanac's Insurance policy is that all claims are submitted to the parent's/guardian's/child's insurance company first:**

Do you carry family medical/hospital insurance? \_\_\_\_\_ If so indicate:  
 Carrier \_\_\_\_\_ Policy ID# \_\_\_\_\_ Group# \_\_\_\_\_

**FEMALE ONLY:**  
 Has this person menstruated? \_\_\_\_\_  
 If not, has she been told about it? \_\_\_\_\_  
 If so, is her menstrual history normal? \_\_\_\_\_  
 Special Needs: \_\_\_\_\_  
 May she use tampons? \_\_\_\_\_

**MISCELANEOUS HEALTH INFORMATION:**  
 Date of most recent Tetanus booster: \_\_\_\_\_  
 Diet Restrictions: \_\_\_\_\_  
 Activity Restrictions: \_\_\_\_\_

**ARE YOU PRONE TO ANY OF THESE?**  
 Sore Throat  Bed Wetting  Sleepwalking  
 Frequent Colds  Ear Infection Type? \_\_\_\_\_  
 Constipation  Fainting  Open Sores  
 Diarrhea  Nose Bleeds Other: \_\_\_\_\_

**PARENTAL AUTHORIZATION**  
 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 by me and/or an examining physician.  
**In the event I cannot be reached,**  
 I hereby give permission to the physician selected by the camp director to order x-rays, routine tests and treatment for the health of my child.  
**In the event I cannot be reached,**  
 In an emergency, I hereby give permission to the physicians selected to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my child as named above.

**LIST THE FOLLOWING INFORMATION:**  
 Environmental Allergies: \_\_\_\_\_  
 Describe reaction: \_\_\_\_\_  
 Drug Allergies: \_\_\_\_\_  
 Describe reaction: \_\_\_\_\_  
 Date of last physical exam: \_\_\_\_\_  
 (must be within the last 24 months)

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 Parent/Guardian/Self (must be 18yrs)  
**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PREVIOUS HOSPITALIZATION:**  
*Date Illness/Surgery/Accident*  
 1 \_\_\_\_\_  
 2 \_\_\_\_\_  
 3 \_\_\_\_\_

**\*\*Please enumerate any other important details of the camper/staff medical or psychological history on additional paper.**  
**ALL MEDICATION** must be kept in the nurse's office and administered by her. All meds must be in **original bottle** with name, med name and dosage.

**MEDICATIONS PRESENTLY TAKING:**

Drug name(s)	Dosage	Reason Taking	Hours Taking
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

**HAVE YOU HAD ANY OF THE FOLLOWING?**

Chicken Pox  Arthritis  Kidney disease  Bleeding or Clotting disorder  
 Measles  Hypertension  Epilepsy  Chronic or reoccurring health problems:  
 German Measles  Rheumatic fever  Diabetes \_\_\_\_\_  
 Mumps  Heart disease/defect  Asthma \_\_\_\_\_

**I hereby release** Camp Sankanac, BCM International, from all liability in administration of the above substances and substances used in treatment of minor injury/illness per camp doctor's standing orders while I/my child is at Camp Sankanac.

**Signature:** \_\_\_\_\_ **(Parent/Guardian/Self) Date:** \_\_\_\_\_

**OFFICE USE ONLY** Week of camp: B 1 2 3 4 / G 1 2 3 4

Camper  Staff Name \_\_\_\_\_ Age: \_\_\_\_ Sex: M F  
 Cabin  Unit \_\_\_\_\_ Counselor \_\_\_\_\_  
 Cabin  Unit \_\_\_\_\_ Counselor \_\_\_\_\_

**NURSE EXAM:** Nurse's Signature: \_\_\_\_\_

Y/N Health information checked with parent, guardian or person bringing to camp.  
 Temperature on arrival (only if sick in last 2 weeks or exam indicates illness).  
 Throat exam notes: \_\_\_\_\_  
 Head lice check: Treatment given: \_\_\_\_\_ Date(s): \_\_\_\_\_  
 Open sores. Describe location and appearance \_\_\_\_\_