Jameson Ranch Health Form

This side to be filled out by parents/guardians of minors or by staff member

Please bring this form when you come to camp

Please attach a copy of your health insurance card here
This form should be filled out within 4 weeks of the applicants stay at camp.

NAME_____ BIRTH DATE_____ SEX_____ AGE _____

PARENT / GUARDIAN _____

HOME ADDRESS_____ PHONE_____

_____ Pager #_____

BUSINESS ADDRESS_____ PHONE_____

SECOND PARENT OR GUARDIAN OR EMERGENCY CONTACT_____

HOME ADDRESS _____ PHONE_____

_____ Pager #_____

BUSINESS ADDRESS_____ PHONE_____

IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY_____

ADDRESS_____ PHONE_____

HEALTH HISTORY
(Check. Give approximate dates)

_____ Frequent ear infection
_____ Heart Defect/Disease
_____ Convulsions / Epilepsy
_____ Diabetes
_____ Bleeding/Clotting Disorders
_____ Hypertension
_____ Mononucleosis

Diseases

_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps

Allergies (Dates not needed)

_____ Hay Fever
_____ Poison Oak, etc.
_____ Insect Stings
_____ Penicillin
_____ Other Drugs
_____ Asthma
_____ Food or Other (Specify)
_____
_____

Operations or serious injuries (Dates)_____

_____

Chronic or recurring illness or medical condition_____

_____

Any non prescription drugs?_____

_____

Dietary Restrictions _____

Name of dentist/orthodontist _____ Phone_____

Name of Family Physician _____ Phone _____

Family health or hospital insurance carrier _____

Policy or Group # _____

Carrier Address _____

Name of person with insurance _____

Concerns or Suggestions on health related information for camp personnel _____

_____

_____

For Female:

Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special consideration _____

EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests and 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. This health history is correct so far as I know and the person herein has permission to engage in all camp activities except as noted

Signature of parent or guardian or staff person _____ Date_____

PHOTO RELEASE I hereby give consent to Jameson Ranch Camp to use for promotion any photograph of my child taken during camp.

Signature of Parent _____

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

Signature of camper or staff person _____ Date _____

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 Immunization or booster	Vaccines	Year of Immunization or booster
DPT: Diphtheria, Pertussis (Whooping cough), Tetanus		Measles (Hard Measles, Red Measles, Rubella)	
TD: Tetanus, Diphtheria		Mumps	
Tetanus		Rubella (German Measles, 3 Day Measles)	
Oral Polio (Sabin)TOPV		Tuberculin test given (most recent)	
Injectable Polio (Salk)		Haemophilus Influenza B (HIB)	
Other		Hepatitis B	

HEALTH EXAMINATION BY LICENSED PHYSICIAN:

I have examined the applicant_____ Date Examined:_____

In my opinion, the applicant may _____ may not _____ participate 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 (including current medications): _____

_____

Explanation of any reported loss of consciousness, convulsions or concussion: _____

_____

Does the applicant currently have any communicable disease? Yes ___ No ____

If yes, What?_____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

Any treatment to be continued at camp: _____

_____

Any medication to be administered at camp (specify dosage): _____

_____

Any medically prescribed meal plan or dietary restriction: _____

_____

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

_____

Activities to be encouraged or limited: _____

_____

Additional health information _____

_____

Licensed Physician's Signature _____Phone (_____)_____

Address _____

Date of form completion _____By_____