

Tamarak Day Camp

23970 North Elm Road, Lincolnshire, Illinois 60069 (847) 634-3168 Fax 634-8262

CAMPER HEALTH HISTORY/MEDICAL EXAM FORM

To be completed by parent/guardian and pediatrician. Must be on file at camp prior to start of camp.

Section A – To be completed by parent/guardian

Name _____ Birth Date ____/____/____ Age at Camp ____
Last First M.I.

Gender male female

Home Address _____
Street City State Zip

General Questions

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Had any recent injury, illness, or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Ever had back problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ever had problems with joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Require an orthodontic appliance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have any skin problems (e.g. itching, rash
acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Had mononucleosis in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had problems with diarrhea/ constipation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Have problems with sleepwalking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out or became dizzy from exercise? ... | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have a history of bed-wetting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever had seizures? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had heart trouble? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Ever had emotional difficulties for which
professional help was sought? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever been diagnosed with a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 14. Ever been diagnosed with a blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Please explain any "yes" answers, noting the number of the question and any other pertinent information?

I authorize Tamarak Day Camp medical personnel to give the following over-the-counter medication(s) to my child as needed. Notification will be provided if dispensed. *Physician must also authorize on the other side.*

	Yes	No		Yes	No
Acetaminophen (Tylenol)	<input type="checkbox"/>	<input type="checkbox"/>	Benadryl (oral)	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen (Advil or Motrin)	<input type="checkbox"/>	<input type="checkbox"/>	Hydrocortisone	<input type="checkbox"/>	<input type="checkbox"/>
Tums	<input type="checkbox"/>	<input type="checkbox"/>	Neosporin	<input type="checkbox"/>	<input type="checkbox"/>

Parent Guardian Authorizations: This health history is correct and complete as far as I know and the person herein described has permission to engage in all camp activities except as noted.

Signed _____ Printed _____ Date _____

Section B on other side to be completed by physician

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Section B – To be completed by licensed medical personnel

Participant Name _____ Birth Date ____/____/____
Last First M.I.

I have examined the above camp participant. Date of examination ____/____/____ BP _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions _____

Current treatment at the time of this report includes _____

Immunizations are current to date according to the Illinois Admin. Code no. 665.270? Yes No

Exemption claimed Yes No Comments _____

Recommendations and Restrictions at camp

Treatment to be continued at camp _____

Any medical-prescribed meal plan or dietary restrictions _____

Description of any limitation or restriction on camp activities and additional information _____

Food Allergies: Yes No If, Yes, a "Food Allergy Action Plan" must be completed prior to camp.

Medication Allergies (list) _____

Other Allergies (list) – insect stings, hay fever, asthma, etc. Include medications provided at camp office. _____

This person takes medication on a routine basis Yes No

If "Yes", complete the following

Medication #1 _____ Dosage & Times day _____

Reason for taking _____

Medication #2 _____ Dosage & Times day _____

Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year the participant does/may not take during the summer

This participant may be dispensed the OTC medication listed on the front of this document with parental permission

Yes No Comments _____

Additional information about the participants behavior, physical, emotional, or mental health about which the camp should be aware.

Signature of Licensed Medical Personnel _____ **Printed** _____ **Date** _____

Address _____ **Phone** _____