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____

Home Address____
Street *City* *State* *Zip*

General Questions

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

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

____

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____

____

____

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)	☐	☐	Benadryl (oral)	☐	☐
Ibuprofen (Advil or Motrin)	☐	☐	Hydrocortisone (anti-itch ointment)	☐	☐
Tums	☐	☐	Neosporin (ointment)	☐	☐

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 and dated within 1 year of 6/1/2021

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 ____

COVID 19 Information

Camper has history of COVID diagnosis ☐ **Yes** ☐ **No** **If yes Date of diagnosis:** _________________

Camper has received COVID vaccinations ☐ **Yes** ☐ **No** **If yes Date of vaccination:** ________________

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** **Attach additional pages for more medications if necessary*

If "Yes", complete the following:

Medication #1____________________________________	Medication #2____________________________________
Dose & Time_____________________________________	Dose & Time_____________________________________
Reason ____	Reason ____

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** __________________________