2010 SPECIAL WEEK CAMPER HEALTH HISTORY FORM

Name____Birthday____/____/____Age_______Sex_______
Last First Middle Initial
Parent or Guardian________________________________Camper Social Security #______________________
Home Address______________________City____________State_______Zip_______ Phone______________
Second Parent or Guardian or Emergency Contact______________________________________
Home Address______________________City____________State_______Zip_______Phone______________
Business____ Phone______________
If not available in an emergency, notify:____
Name________________________________Relationship to You________________________
Address____ Phone______________

Health History
(Give approximate date.)
______Frequent Ear Infections
______Heart Defect/Disease
______Seizures
______Diabetes
______Bleeding/Cotting Disorders
______Hypertension
______Mononucleosis
______Psychiatric Treatment
______Recent Head Lice Infestation
______Frequent Sore Throats
______Stomach Upsets
______Bed Wetting
______Sleepwalking
______Menstrual Problems

Diseases
______Chicken Pox
______Measles
______German Measles
______Mumps

Allergies (Date not needed.)
______Hay Fever
______Ivy Poisoning, etc.
______Insect Stings (How Severe)
______Penicillin
______Other Drugs
______Asthma
______Other (specify)______

Immunization History - Please record the date (month and year) of basic immunizations and most recent booster doses. A photocopy of the current immunization history wll be accepted.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussia (Whooping Cough) Tetanus		
Tetanus Diphtheria		
Tetanus		
Oral polio (Sabin)		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3 - day measles)		
other		
Tuberculin Test Given (Most recent)		
Haemophilus influenza b		

Operations or serious injuries (dates) ____
Disability or chronic or recurring illness ____
Physical, emotional or mental handicaps ____
Activities encouraged or limited by physician ____________________________________
Dietary modifications ____
Current medication (send with instructions)______________________________________
Other diseases or details of above ____
Name of dentist/orthodontist______________________________Phone______________
Name of family physician ________________________________Phone______________
Do you carry family medical/hospital insurance?________yes_______no
If so, indicate: Carrier ______________________________Policy or Group #____________________
Suggestions on health related information for camp personnel ____________________________
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Is there anyone who is legally restricted from seeing the camper?________yes_______no
If yes, Name______________________________Relationship to Camper____________________

- **By signing this health form, I certify that the above named camper has received a physician's health examination within the past 24 months and has been cleared to participate in all camp activities. Date of Last Physical Examination:____________________**

Physician who performed exam:________________________________ Phone____________________

I hereby certify that the health history information provided for the camper named above is correct so far as I know, and the person named herein has my permission to engage in all prescribed camp activities except as noted. **Authorization for Treatment:** I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to Black Rock Retreat Health Care Staff to administer over the counter, non prescription medications such as Tylenol, Ibuprofen, cough syrup, antacids, etc. as needed. I give permission to the Health Care Manager and staff selected by Black Rock Retreat Personnel to administer prescribed medication as listed on this form, to perform treatment for minor injuries and illnesses, and to perform First Aid or CPR in the event of a more serious injury or illness. In the event I cannot be reached during an emergency, I herby give permission for personnel selected by Black Rock Retreat to provide emergency care and treatment tothe above named camper in the event of injury or illness. I also give persmission for Black Rock personnel to secure needed professional medical treatment by a physician, EMS or Emergency Room hospital staff as needed and to order X-rays, routine tests, treatment, and any necessary related transportation for me/or my child.

***Signature of parent or guardian or camper if not a minor________________________________**
Witness________________________________Date____________________

***If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver, which must be signed for attendance.**