OCEANWOOD YOUTH HEALTH FORM

This Health Form and the Signed Physical Examination or the campers most recent physical paperwork dated within the past 12 months from the start of camp **must be received by the office two weeks prior to your arrival at camp**

CAMPER INFORMATION

Camper's Name: _____ Date of Birth: _____ Age: _____

Phone Number: _____ Social Security Number: _____ Male ( ) Female ( )

Address: _____

City: _____ State: _____ Zip Code: _____

CONTACT INFORMATION (While at Camp & During the Year)

Parent/Guardian #1: _____ Day Phone: _____ Alt: _____

Relationship to Camper: _____ Address: _____

Parent/Guardian #2: _____ Day Phone: _____ Alt: _____

Relationship to Camper: _____ Address:_____

If not available in an emergency, notify:

Name: _____ Phone: _____ Alt: _____

Relationship to Camper: _____ Allowed to Make Medical Decisions: Yes ( ) No ( )

INSURANCE INFORMATION & REQUEST FOR YEARLY PHYSICAL*

Insurance coverage for accidents or illness while participating at Oceanwood are the responsibility of the Camper and/or their family. **Please include a copy of your current insurance card.**

Carrier: _____ Policy or Group No. _____

Medicare / Medicaid No. _____ Policy Holder Name: _____

Address of Carrier: _____ City: _____ State: _____ Zip: _____

A CURRENT PHYSICAL (WITHIN THE PAST 12 MONTHS OF THE CAMP START DATE) IS REQUIRED FOR PARTICIPATION AND ACCEPTANCE INTO OCEANWOOD PROGRAMMING

IMPORTANT - MUST BE COMPLETED FOR ATTENDANCE

Authorization: This part should be signed by the parent/guardian if the camper or staff member is under 18. Staff over 18 must sign for themselves.

This health history is correct and complete to be the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by the Director to order x-rays, routine tests, treatment, to release any records necessary for insurance purposes, and to provide or arrange necessary transportation for myself or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the Physician selected by Oceanwood to secure and administer treatment, including hospitalization, for the person named above. I also give permission to trained camp personnel to administer any first aid should a situation requiring medical attention occur while at camp. I further give permission to the camp nurse to administer prescription medication (as noted) and over-the-counter medications. I give permission for this form to be photocopied for off-camp trips. I understand the inherent risks associated with outdoor recreation and camp activities, and do not hold the camp liable for any injuries or death incurred while attending camp.

Signature: _____ **Date:** _____

Printed Name: _____

HEALTH HISTORY: The intent of this information is to provide Oceanwood Medical Staff the background to provide appropriate care. Any changes to this form should be provided to Oceanwood upon arrival. Please provide complete information so that Oceanwood can be aware of your needs.

ALLERGIES: List all known allergies and describe the reaction and management of any reactions

MEDICATION ALLERGIES:

_____ _____

_____ _____

_____ _____

FOOD ALLERGIES:

_____ _____

_____ _____

_____ _____

OTHER ALLERGIES: Include insect stings, seasonal allergies, asthma, animal allergies, etc.

_____ _____

_____ _____

_____ _____

MEDICATION RECORD

☐ **This Camper does not take any medications on a routine basis and comes to camp with no medications.**

Drug Name Exactly as Dispensed	Dosage & How its Administered	Time(s) & Day(s) Given	Reason(s) for Medication

PLEASE DO NOT SEND IN ANY OVER THE COUNTER MEDICATIONS AS OUR HEALTH OFFICE IS STOCKED WITH EVERYTHING OUR CAMPERS NEED.

RESTRICTIONS & RECOMMENDATIONS WHILE AT CAMP

List any Dietary Restrictions, Medically-Prescribed Meal Plans, or any Special Diets (gluten-free, low salt, etc):

_____

_____

_____

Camper **does not** eat: ( ) Beef ( ) Seafood ( ) Eggs ( ) Pork ( ) Dairy Products ( ) Other: _____

List any **restricted** activities: _____

List any activities the Camper **enjoys**: _____

List any activities the Camper **dislikes**: _____

UNDERSTANDING THE CAMPER

Does the Camper have: ( ) Diabetes ( ) Seizures ( ) ADHD/ADD ( ) Visual Impairment
( ) Mobility Impairment ( ) Hearing Impairment ( ) Recurring Illness ( ) Other: _____
Please provide any treatment, protocols followed, or any other information on checked items:

_____

_____

Please check if the Camper is subject to any of the following:
( ) Sunburn ( ) Urinary Infections ( ) Bedwetting ( ) Constipation ( ) Diarrhea ( ) Vaginal Infections
( ) Sinus Infection ( ) Bronchitis ( ) Pneumonia ( ) Frequent Colds ( ) Ear Infections ( ) Sore Throat
( ) Asthma ( ) Dizziness/Fainting ( ) Nausea/Vomiting ( ) Anxiety ( ) Panic Attacks ( ) Skin Rash
( ) Back Problems ( ) Joint Problems ( ) Hernia ( ) Frequent Headaches ( ) High Blood Pressure
( ) Chest pain during/after exercise ( ) Passed out during/after exercise ( ) Heart Abnormalities
( ) Sleepwalking ( ) Abnormal Menstrual History ( ) Eating Disorder ( ) Emotional Difficulties
Please explain any items marked off above: _____

_____

_____

*** Is Camper required to carry an EPI pen?** ( ) No ( ) Yes - **Please pack & Provide Dr. Note**

*** Is Camper required to carry an inhaler?** ( ) No ( ) Yes - **Please pack & Provide Dr. Note**

Camper **must**: ( ) **Not** get water in ears ( ) Stay **out** of water ( ) Wear ear plugs when swimming
Has the Camper: ( ) Been hospitalized ( ) Ever had surgery ( ) Ever had a head injury/Been Unconscious
( ) Had mononucleosis in the past 12 months ( ) Other: _____

Please comment on the above checked items & pack anything required for treatment/management:

_____

_____

Has the participant had any of the following and if so, when?
( ) Measles: _____ ( ) Chicken Pox: _____ ( ) German Measles: _____
( ) Mumps: _____ ( ) Hepatitis: _____
( ) TB Mantoux: _____ Last Test Date: _____ Result: ( ) Positive ( ) Negative

Please let us know of any additional information you feel the camp should be aware of: _____

_____

_____

_____

ADAPTIVE DEVICES

Please check off and **send** any adaptive devices the Camper uses on a regular basis:
( ) None ( ) Hearing/Communication Aids ( ) AFO's or Braces ( ) Glasses/Contacts ( ) Nebulizer
( ) Other: _____

Please provide any specific instructions on use and care of any adaptive devices:

_____

_____

Family Physician: _____ **Phone:** _____
Dentist or Orthodontist: _____ **Phone:** _____

PHYSICAL EXAMINATION

Please be accurate & up-to-date within the previous 12 months to the Camper's session date. Physical examination form must be completed & signed by a LICENSED PHYSICIAN or attach the Physicians Form

Camper Name: _____ **Session Dates:** _____

Height: _____ **Weight:** _____ **BP:** _____

In my opinion, the above camper ( ) IS or ( ) IS NOT able to participate in an active camp program

Camper is under the care of a physician for the following condition(s): _____

_____

Current treatment at the time of this examination includes: _____

_____

Any treatment to be continued at camp: _____

_____

RECOMMENDATION & RESTRICTIONS

Known Allergies: _____

_____

Medications to be administered at camp (name, dose, frequency): _____

_____

Any medically prescribed meal plan or dietary restrictions: _____

_____

Description of any limitations or restrictions on camp activities: _____

_____

Please list any additional information: _____

_____

IMMUNIZATIONS & DATES GIVEN

Tetanus/Diptheria: _____, _____, _____, _____ **Tetanus:** _____, _____, _____, _____

Polio: _____, _____, _____, _____ **DTP:** _____, _____, _____, _____

MMR or MMRV: _____, _____, _____, _____ **or Measles:** _____, _____, _____, _____

or Mumps: _____, _____, _____, _____ **or Rubella:** _____, _____, _____, _____

Haemophillus Influenza B: _____, _____, _____, _____ **Hepatitis B:** _____, _____, _____, _____

Varicella: _____, _____, _____, _____ **BCG:** _____, _____, _____, _____

Rotavirus: _____, _____, _____, _____ **Hepatitis A or C:** _____, _____, _____, _____

HPV: _____, _____, _____, _____ **Meningococcal Influenza:** _____, _____, _____, _____

Examining Physician: _____ **Date:** _____

Signature: _____ **Practice Name:** _____

Address: _____ **Phone #:** _____