Camp Gilmont Health History and Examination Form Dates of Camp Attendance ______________________________

Name ____
Last First Middle

Birth date ____ Age at camp ______________________

Home address ____
Street Address City State Zip

Gender: ☐ Male ☐ Female

Parent/guardian ______________________________________ Phone____

Home address (If different from above) ____
Street Address City State Zip

If not available in an emergency, notify ____

Relationship ____ Phone ______________________

Address____
Street Address City State Zip

Important — These boxes must be complete for attendance*

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer ____

Printed Name____ Date

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer ____ Date

Health History

The following information must be filled in by the parent/ guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

Food allergies (list)

Other allergies (list) — include insect stings, hay fever, asthma, animal dander, etc.

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

- ☐ Can not eat red meat
- ☐ Can not eat pork
- ☐ Can not eat eggs
- ☐ Can not eat poultry
- ☐ Can not eat seafood
- ☐ Can not eat dairy products
- ☐ Other (describe)

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary)

Name of family physician____

Phone____

Address____

Name of family dentist/orthodontist ____

Phone____

Address____

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on __________________. (ACA-accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. **A new exam is not necessarily required for camp attendance**.)

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

Recommendations and Restrictions at Camp

Treatment be continued at camp

Medications to be administered at camp (name, dosage, frequency)

Any medically-prescribed meal plan or dietary restrictions

Known allergies

Description of any limitation or restriction on camp activities

Additional information for health care staff at the camp

Signature of Licensed Medical Personnel ______________________________

Printed ______________________________ Title ______________

Address ______________________________

Phone ______________________________ Date ______________