Pathfinder Country Day Camp Health History and Examination Form Page 1
Children, Youth and Adults Attending Camps 20___

Mail/fax after April 1st : Pathfinder P.O. Box 807 Montauk, New York 11954 Fax: 631 668 2075

All 3 pages must be completed & reviewed by Camp Nurse before attending Pathfinder.

Last Name:___________________________ First Name:________________________ M or F

Age at camp:______ Date of Birth: _______________Custodial parent/guardian:______________________

Winter Phone:_________________ Business Phone:_________________________

Winter Address: Street:______________________ City: _____________ State:____________ Zip:______
Business Address: Street:____________________ City: _____________ State:____________ Zip:______
Summer Address: Street:____________________ City: _____________State: ____________ Zip:________

Parent Summer Contact Information: Home Phone: ____________________Mobil:____________________

If not available in an emergency, notify:
Name:____________________________________ Relationship:_______________________________

Medical Insurance? Yes( ) No ( ) Information: Is the participant covered by family medical/hospital ins.? Y N

Insurance Company Name:_________________________ Primary Card Holder:_____________

Policy Number:_________________ Group Number:________________ Relationship to participant:__________

Please attach a copy of your insurance card, front and back, to the completed medical form.

Security Information:
If you are not available, who has permission to pick up your child? (Person must bring picture ID)
1.Name:______________________Relationship:______________ Does Child Know this Person?______

2.Name:______________________ Relationship:______________ Does Child Know this Person?______

3.Name:______________________Relationship:______________Does Child Know this Person?______

Health History: Allergies: list all known

Medication allergies (list)
1__________________ Reaction:____
2__________________ Reaction:____
3__________________ Reaction:____

Food Allergies (list)
1__________________ Reaction:____
2__________________ Reaction:____
3__________________ Reaction:____

Other Allergies (list)-include insect stings, hay fever, asthma, animal dander, etc
1__________________ Reaction:____
2__________________ Reaction:____
3__________________ Reaction:____

Medications Being Taken

Please list all medications, including over the counter/non prescriptive drugs, taken routinely. If medication is going to be taken at camp, please bring enough to last the duration the child is attending Pathfinder.
If it is a prescription drug, keep it in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage and the frequency of medication. Please make sure all medication is not out of date.

( ) This child/staff takes medications as follows:
Medications #1________________________Dosage______________Specific times taken each day___________
Reason for Taking____
Medications #2________________________Dosage______________Specific times taken each day___________
Reason for Taking____
Medications #3________________________Dosage______________Specific times taken each day___________
Reason for Taking____

( ) This child/staff takes NO medications on a routine basis

( ) Staff: Have you ever been treated for mental illness, mental disease or other psychological or emotional disorder?
Explain:____

Last Name:________ First Name:________ Age:____ Male/Female Allergies: Y N Allergen:________

Page 2: Name:____

Parent/Guardian(18 yrs and older), may complete this page.

Restrictions: The following restrictions apply to this individual.

Dietary: Does not eat: ( )red meat ( )poultry ( )pork ( )seafood ( )eggs ( )dairy products

( )Other (describe)____

Restrictions to Activities: Explain limitations to activity or restrictions:____________________________________

____

General Questions: Y=yes N=no, circle one

1. Had any recent injury, illness or infectious disease? Y N
2. Have a chronic or recurring illness or condition? Y N
3. Ever been hospitalized? Y N
4 Ever had surgery? Y N
5. Ever been knocked unconscious? Y N
6. Have frequent headaches? Y N
7. Ever had a head injury? Y N
8. Wear glasses, contacts, protective eye wear? Y N
9. Ever had frequent ear infections? Y N
10. Ever passed out during or after an exercise? Y N
11. Ever been dizzy during or after an exercise? Y N
12. Ever had seizures? Y N
13. Ever had chest pain during or after and exercise? Y N
14. Ever had high blood pressure? Y N

Please explain any "yes" answers, noting the number of the question you are referring to:

15. Ever been diagnosed with a heart murmur? Y N
16. Ever had back problems? Y N
17. Ever had problems with joints, knees, ankles? Y N
18. Have an orthodontic appliance being brought to camp? Y N
19. Ever have skin problems, rash, acne, itching? Y N
20. Have Diabetes? Y N
21. Have asthma? Y N
22. Have mononucleosis in the last 12 mths? Y N
23. Problems with diarrhea/constipation? Y N
24. Have problems with sleepwalking? Y N
25. If female, have an abnormal menstrual history? Y N
26. Have history of bed-wetting? Y N
27. Ever had an eating disorder? Y N
28. Ever had emotional difficulties for which professional help was sought? Y N

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Please use this space to provide the camp with any necessary information about the participant. It is important to include behavior, emotional or mental health and physical disabilities. This will help us better your child's camp experience if you allow us to understand and be aware.____

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Parent/Guardian Authorizations: Please read and completed for attendance.

This health history is correct and completed as far as I know. The person herein described has permission to engage in all camp activities except noted. I hereby give permission to the camp to provide routine heath care, administer prescribed medications, seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission for the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the nurse/physician selected by the camp to secure and administer treatment, including hospitalization, for the named person above.

This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or staff:____

Print Name:____Date:________

Minor /Staff: I agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or staff:____Date:________

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

For Camp Use Only:

Screening Record: Date Screened_______________ Time: _________am pm

Meds received: ( )yes ( )no if yes, describe:____

Observational Notes:____

____

Screened By______________________________ Date screened:____________________________________

Pathfinder Country Day Camp Summer 20____

This page must be completed by a Physician or Licensed Medical Personal **Page 3**

P.O. Box 807 Montauk, New York 11954 ph: 631 668 2080 fax: 631 668 2075

Name:____ **Date:**____________

Immunizations: Which of the following has the participant had?

( )Measles ( )Chicken Pox ( )German Measles ( )Mumps ( )Hepatitis A ( )Hepatitis B ( )Hepatitis C

( ) TB Mantoux Test Date of last test:__________ Result: ( )Positive ( )Negative

Vaccine	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year
DTP							
TD (Tetanus/diphtheria)							
Tetanus							
Polio							
MMR							
Or measles							
Or mumps							
Or Rubella							
Haemophilus influenza B							
Hepatitis B							
Varicella (chicken pox)							

Give all dates of immunizations. **You may attach a copy of immunizations to medical form.** This is mandatory by the Suffolk County Board of Health & NYS. You may ***not*** attend Pathfinder without a copy in our health office ***prior*** to camp.

*****If your child is not immunized, please attach a written a note of explanation (religious, choice, etc).** ***This is explanation is mandatory by Suffolk County Board of Health & New York State.***

Health Care Recommendations By Licensed medical Personal:

I examined this individual on (date):__________________. 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 to be continued at camp:____

____

Medications to be administered at camp:

Name of Medication:____

Dosage: _____________________________________Frequency:____

Any medically-prescribed meal plan or dietary restrictions:____

____

Known allergies:____

Description of any limitations or restriction on camp activities:____

____

Additional information for health care staff at Pathfinder:____

____

Signature of Licensed Medical Personal:____

Print Name:______________________________ **Title:**____

Address:____

PH#:_________________________________**Date:**______________________________