

Camp Farley Outdoor Education Center

615 ROUTE 130 MASHPEE, MA 02649 (508) 477-0181 Fax (508) 539-0080 office@campfarley.com

Health History and Examination Form for Children Attending Camp

**DO NOT MAIL THIS FORM!!!
PLEASE BRING THIS FORM WITH OTHER CAMP
FORMS ON YOUR CHILD'S FIRST DAY OF CAMP!!!**

Part 1: Health History - required for all campers. Completed no more than 3 months before the start of camp.

MA State Law requires ALL campers have a current Health Form on file before they can participate at camp.

Part 2: Physical Examination- required for overnight campers only. - To be completed by your child's health-care provider.

PART 1: CAMPER INFORMATION

Name of Camper: _____ Date of Birth: _____ Age: _____ Gender: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Day Phone: _____ Night Phone: _____

PARENT/GUARDIAN EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Camper: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Name: _____ Relationship to Camper: _____
Street Address: _____ City: _____ State: _____ Zip: _____

General Health History:

Ever been Hospitalized _____	Asthma/Shortness of Breath _____	Chest Pain _____	Rheumatic Fever _____
Had Surgery _____	Seizures _____	Fainting/Dizziness _____	Measles _____
Sleepwalking _____	Headaches _____	Diarrhea/ _____	Mumps _____
Bed Wetting _____	Diabetes _____	Constipation _____	German Measles _____
Recent injury _____	Kidney Trouble _____	Chicken Pox _____	Other _____
Anxiety/Depression _____	ADD/ADHD _____		

Describe current physical, mental or psychological conditions requiring medication, treatment or special instructions while at camp

For Females: Has this person menstruated? _____ If not, has she been told about it? _____ If so, is menstrual history normal? _____

Allergies: No Known allergies _____ Food _____ Medicine _____ Environmental _____ Other _____

Please describe below what the camper is allergic to and the reaction

Dietary Restrictions _____

Current Doctor: _____ Phone with Area Code: _____
Current Dentist: _____ Phone with Area Code: _____
Orthodontist: _____ Phone with Area Code: _____

Insurance: Subscriber: _____ Company: _____ Policy #: _____

Parent/Guardian Authorization for Health Care: This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment and necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director or camp healthcare provider to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for emergency use.

Signature of Parent/Guardian: _____ **Date Signed:** _____
**If for religious or other reasons you cannot sign this, then the camp should be contacted for a legal waiver which must be signed for attendance.*

Immunization History For All Campers: Provide month/ year for each immunization. Starred (*) immunizations must be current. Copies from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis*(DTaP) or (Tdap) 4 doses DTaP/DTP/DT or 3 doses of TD						
Tetanus booster *(dT) or (Tdap) Grades 7-10 need booster if >5 yrs since last dose. Grades 11-12 booster if >10 yrs since last dose.						
Mumps, Measles, Rubella *(MMR) 1 st dose+12 mos or older 2 nd dose=grades K-12						
Polio* (IPV) (3 doses IPV or OPV, or 4 doses mix IPV/OPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B* 3 doses if born on or after 1/1/92						
Hepatitis A						
Varicella (chicken pox) Had chicken pox Date:						
Meningococcal Meningitis (MCV4)						
Tuberculosis (TB) test Date:	Negative	Positive				

If camper is not fully immunized, please sign the following statement: **I understand and accept the risks to my child from not being fully immunized.**

Signature of Parent or Guardian _____ Date: _____ Relationship to Camper: _____

PART 2: MUST BE COMPLETED FOR OVERNIGHT CAMPERS by Licensed Physician or Healthcare Provider

Physical exam done within last 24 months ___ Yes ___ No Date of last physical: _____
State laws specify physical exam within last 24 months. *Month/Day/Year*

Height: ___ ft ___ in Weight: _____ lbs Blood Pressure: _____ / _____

Allergies: *Please describe below what the camper is allergic to and the reaction*

- ___ No Known Allergies
- ___ Food _____
- ___ Medicine _____
- ___ Environmental (insect stings/hay fever/etc) _____
- ___ Other (list) _____

Current Medications:

- ___ No daily medications
- ___ Will be taking the following prescribed medications while at camp (name, dose, frequency - describe)

Recommendations and/or Restrictions While at Camp

Do you feel that the camper will require limitations or restrictions to activity while at camp? ___ No ___ Yes
 If yes what do you recommend? _____

I have reviewed the CAMPER HEALTH HISTORY FORM and have discussed the camp program with the camper's Parent/Guardian. It is my opinion that this camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Licensed provider: (please print): _____ Signature: _____ Title: _____

Office Address: _____

Telephone: _____ Date: _____