



301 Gwynn Valley Trail
 Brevard, NC 28712
 (828)885-2900 phone
 (828)885-2413 fax
 www.gwynnvalley.com

Session(s) attending camp _____
 The participant is a camper staff member

HEALTH HISTORY and EXAMINATION FORM

For overnight Campers and Staff

This form must be returned by May 1st.

Pages 1-3 must be completed by the **Parent/guardian or staff member** each year.
 Page 4 (the physical exam) is required within 24 months of camp attendance, and is to be completed by **Licensed Medical Personnel**.

Please be sure to make a photocopy of the completed form for your records.

Please complete this form as thoroughly and accurately as possible to better help our medical staff care for your child or you as a staff member. (If there is a change to any information before the participant's arrival at camp, you must provide camp with the new info.)

To be completed by the parent/guardian or staff member

Participant Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address _____
Street address City State Zip

Social Security Number of participant _____ Gender: Male Female

Custodial parent/guardian _____

Home Address _____
(if different from above) Street City State Zip

Home Phone _____ Cell _____ Work Phone _____

Second parent/guardian _____

Home Address _____
(if different from above) Street City State Zip

Home Phone _____ Cell _____ Work Phone _____

If not available in an emergency, notify _____ Relationship _____

Phone #s home _____ cell _____ work _____

Address _____
Street address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____

Please photocopy the front and back of health insurance cards and attach them to this form.

Family Physician: _____ Dentist / Orthodontist: _____
 Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

To be completed by the parent/guardian or staff member

The camper is receiving treatment for the following conditions: _____

Please list all Medications (including non-prescription) taken on a regular basis. Be sure to include all behavioral/emotional medications, and be specific about the reason for taking. In order to not disrupt your child's camp experience, medications are routinely given before breakfast/lunch/dinner. Exceptions will be made on an as-needed basis.

- No medications are taken on a regular basis.
- The participant takes the following medications.

CURRENT MEDICATIONS (please bring the prescription package with Physician's dosage on Opening Day)

This person takes medications as follows:

Med #1 _____ Dosage _____ Times taken daily _____ Reason for taking _____

Med #2 _____ Dosage _____ Times taken daily _____ Reason for taking _____

Med #3 _____ Dosage _____ Times taken daily _____ Reason for taking _____

Please attach additional pages for more medications. If your child is on a psychotropic medication and you are planning to or have made a change in that medication (any time up to six weeks) before camp, please discuss it with us. Please list any medications the participant takes during the school year, that he/she will not be taking during the summer. _____

List all known Allergies. Please be specific about what reaction occurs (i.e. rash, shortness of breath, etc.) and management of the reaction (i.e. antihistamine, epi-pen, etc.).

Medicine _____
 Food _____
 Environment _____
 Other _____

Please list any diet restrictions that apply to this individual: _____

Please list any restrictions to activities, including adaptations or limitations that are necessary: _____

Immunizations (MUST BE COMPLETED EACH YEAR)

Vaccine:	All dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTaP / TdaP						
Tetanus:						
Polio:						
MMR:						
Haemophilus influenza B:						
Hepatitis B (completed):						
Hepatitis A						
Varicella (chicken pox):						
TB Test:						
Pneumococcal PCV						
Meningococcal Meningitis (MCV4)						

To be completed by the parent/guardian or staff member

Has/does the participant:	Yes:	No:		Yes:	No:
1. Have diabetes?			11. Have skin problems (rash, acne...)?		
2. Have asthma/wheezing/shortness of breath?			12. Had problems with constipation/diarrhea?		
3. Have chronic or recurring illness/condition?			13. Had seizures?		
4. Had frequent headaches or a head injury?			14. Had back problems or joint problems?		
5. Had surgery or been hospitalized?			15. Have problems with sleepwalking or bedwetting?		
6. Had chest pain during or after exercise?			16. Have an abnormal menstrual history?		
7. Passed out or become dizzy during exercise?			17. Wear glasses or contacts		
8. Had mononucleosis in the past 12 months?			18. Ever been treated for emotional or behavioral difficulties or an eating disorder?		
9. Had frequent ear infections?			19. During the past 12 months, seen a professional to address mental/emotional health concerns?		
10. Recently had an injury, illness, or infectious disease?			20. Had a significant life event that continues to affect the camper's life? (Abuse, death of loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.)		

Please explain any "yes" answers. _____

Please provide any additional information which will help the medical staff better serve the camper: _____

In order to participate at Gwynn Valley, this box must be completed.

This health history is complete as far as I know. I have reviewed the program and activities of the camp and the person described herein has permission to engage in all prescribed camp activities except as noted. I give my permission to photocopy this form for trips out of camp. I understand that information on this form will be shared on a "need to know" basis with camp staff. I also give my permission to the camp's medical staff to speak with my child's physician or health care provider if needed. I hereby give permission to the medical personnel selected by the camp to order x-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the medical personnel selected by the camp to secure and administer treatment, including hospitalization, injection, anesthesia, or surgery for this child as named above.

I have attached a copy of the front and back of the participant's health insurance card to this form.

Signature of parent or guardian or adult staff _____ Date _____

Printed Name _____ Relationship to Camper _____

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

To be completed by Licensed Medical Personnel

(The exam must be performed within two years of the participant's time at camp.)

Date of exam: _____ Name of Camp Participant _____

BP _____ Weight _____ Height _____

The participant 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: _____

Medically prescribed dietary restrictions: _____

Known allergies: _____

Limitations or restriction on activities at camp: _____

Additional information for camp health care staff: _____

- The participant is able to participate in an active camp program.
- The participant is NOT able to participate in an active camp program.

Signature of Licensed Medical Personnel _____ Date _____

Printed name _____ Address _____

Title _____

Phone _____