

**CAMP MATOAKA HEALTH SERVICES – 2008 HEALTH HISTORY AND EXAMINATION FORM - CAMPER**

One Great Place, Smithfield, ME 04978-1288 Tel: (207)-362-2500 Fax: (207)-362-2525 email: nurses@matoaka.com  
The information on this form is used to identify appropriate health care, not to screen out campers. These forms are confidential and kept separate from other personnel records. This **original form** is required at camp by **June 2<sup>nd</sup>**.

**Pages 1 and 2 must be filled out by parents/guardians of camper.**

**NO health care, including regular medication, can be given without this form.**

NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_  
*Last First Middle*

HOME ADDRESS \_\_\_\_\_  
*Street Address City State Zip Code*

SOCIAL SECURITY NUMBER OF CAMPER \_\_\_\_\_

PARENTS/GUARDIANS \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
*(if different from above) Street Address City State Zip Code*

EMAIL ADDRESS \_\_\_\_\_ FAX \_\_\_\_\_

DAD WORK# \_\_\_\_\_ MOM WORK# \_\_\_\_\_ DAD CELL# \_\_\_\_\_ MOM CELL# \_\_\_\_\_

CREDIT CARD # \_\_\_\_\_ EXP DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ Mastercard \_\_\_\_\_ Visa \_\_\_\_\_

Name on Credit Card (please print) \_\_\_\_\_ Signature of card holder \_\_\_\_\_

WILL YOU BE AT THE ABOVE ADDRESS FOR THE ENTIRE SUMMER?  YES  NO  
If NO, please email Leslie at [leslie@matoaka.com](mailto:leslie@matoaka.com) with your travel itinerary.

IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ WORK PHONE # \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

Health History	Diseases	Allergies (Epi Pen required Y / N)
<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Heart defects/diseases	<input type="checkbox"/> Measles	<input type="checkbox"/> Other drugs _____
<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> German Measles	<input type="checkbox"/> Bee Stings
<input type="checkbox"/> Bleeding/Clotting Disorders	<input type="checkbox"/> Mumps	<input type="checkbox"/> Asthma
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Fifth's Disease	<input type="checkbox"/> Food Allergies please list
<input type="checkbox"/> Mononucleosis		

**INSURANCE INFORMATION**

THIS INFORMATION IS REQUIRED FOR YOUR CAMPER TO BE SEEN IN A HOSPITAL OR DOCTOR'S OFFICE. CAMP DOES NOT SUBMIT CLAIMS ON BEHALF OF CAMPERS TO INSURANCE COMPANIES. THE CAMP SHALL NOT BE LIABLE FOR ANY EXCESS OR AMOUNTS NOT COVERED BY HEALTH CARE PROVIDER BELOW.  
**PLEASE ATTACH A COPY OF YOUR INSURANCE CARD WITH THIS FORM.**

Medical Insurance or Health Care Coverage provided by \_\_\_\_\_

Personal Identification # \_\_\_\_\_

Group coverage under the name of \_\_\_\_\_

Insurance Company Billing address \_\_\_\_\_  
*Street Address City State Zip Code*

Company telephone number \_\_\_\_\_

**IMPORTANT – THIS BOX MUST BE COMPLETE FOR ATTENDANCE**

To the best of my knowledge, this health history is correct and complete, and the person herein described has permission to engage in all prescribed 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 transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer any/all of my child's medical records as requested by the attending camp staff member.

**Authorization of Health Insurance:** I hereby give my permission to the camp director to submit my Health Insurance coverage as an authorized third party. This form may be photocopied for trips out of camp.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(PARENT OR GUARDIAN OF CAMPER) \*REQUIRED\*

The following information **must be filled in by the parent/guardian of the camper.**

NAME OF FAMILY PHYSICIAN _____	PHONE _____
NAME OF DENTIST/ORTHODONTIST _____	PHONE _____
If camper wears eyeglasses, contact lenses NAME OF EYE PHYSICIAN _____	PHONE _____
PRESCRIPTION: L _____ R _____	Is camper bringing spare pair? _____

Please complete the following questions with as much information as possible. Use additional sheet if necessary.

\*\* If your daughter will be coming to camp with any medication please contact **CVS Pharmacy at 207-873-7161 and ask for Cheryl Blaisdell, Sandra Brochu or Beth Bois.****1. ALLERGIES** List all known.

Medication allergies (list) \_\_\_\_\_

Food allergies (list) \_\_\_\_\_

Other allergies (list – include insect stings, hay fever, asthma, etc.) \_\_\_\_\_

**2. MEDICATION**Medication(s) to be given at camp (parents must **register with CVS and complete additional medication form**)**Any** medication **not** to be given? If so, what, (give reason). \_\_\_\_\_Has your child been taking **any** prescription medication during the last 12 months? If so, please explain. \_\_\_\_\_Will your child continue to take this medication during her time at camp?  YES  NO

If no, please explain. \_\_\_\_\_

When did your child start each medication? \_\_\_\_\_

**Please note that your child may not begin, change, or alter dosages of any chronic medications after May 1<sup>st</sup>.**

Any prescription preferences should your child require any medication while at camp, (i.e., antibiotic choice, type - liquid, chewable, tablet, generic equivalents). \_\_\_\_\_

3. **Any** surgical operations? \_\_\_\_\_4. **Any** hospitalizations? \_\_\_\_\_5. **Any** serious injuries, including fractures/dislocations? \_\_\_\_\_6. **Any** chronic or recurring illness? \_\_\_\_\_7. **Any** loss of consciousness, convulsions or concussions? \_\_\_\_\_8. **Any** camp activities to be restricted? \_\_\_\_\_

9. Does your child exhibit any particular characteristics when unwell? \_\_\_\_\_

10. Details of any specific health care your child may require while at camp. \_\_\_\_\_

11. Has camper menstruated? If no, does she know about it? \_\_\_\_\_

12. Is camper presently being treated or under the supervision of any doctors, therapists, social workers, etc.? If yes, please explain.

*Additional comments, including any concerns you would like our staff to pay particular attention to, should be included on an additional sheet.***\*\*FULL MEDICAL DISCLOSURE IS MANDATORY\*\***

**This side to be filled in by licensed physician - please do not separate.**

The camp relies upon the truth and accuracy of this information, not to discriminate, but to determine the appropriateness of this placement, and the camps' ability to accommodate the child, as part of its decision to accept or reject any camper.

**CAMPER NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_

**IMMUNIZATION HISTORY**

Please record the date, (month and year), of basic immunizations and most recent booster doses.

VACCINES	YR OF BASIC IMMUNIZATION	YEAR OF LAST BOOSTER
Diphtheria /Pertussis/Tetanus, (DPT)	1 2 3	1 2
Tetanus/Diphtheria, (DT)		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles, (hard measles, red measles, rubeola)		
Mumps		
Rubella, (German Measles, 3 day Measles)		
Other		
Tuberculin test given _____ (most recent)		
Hemophilus Influenza b (HIB)		
Hepatitis B		

Height \_\_\_\_\_ Weight (lbs) \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Blood Type (if known) \_\_\_\_\_

**HEALTH CARE RECOMMENDATIONS BY LICENSED PHYSICIAN**

I have personally examined the above named camp applicant on \_\_\_\_\_ (examination date).

In my opinion, full participation in camp activities should be permitted except for the following:

\_\_\_\_\_

The applicant is under the care of a physician, therapist, etc, for the following condition(s). \_\_\_\_\_

\_\_\_\_\_

Current treatment of above, (include medications) \_\_\_\_\_

\_\_\_\_\_

Is treatment to be continued at camp? If yes, give details. If no, please explain, and indicate possible side effects to watch for.

\_\_\_\_\_

Any allergies (drugs, foods, plants, insects, etc)? \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions? \_\_\_\_\_

Additional health information from physicians, therapists and social workers. \_\_\_\_\_

Name of Physician _____	Signature _____	Date _____
Address _____	Phone _____	

## CAMP MATOAKA IN-CAMP HEALTH SCREENING RECORD

This side is for camp use by Health Center staff only. All Health Center visits will be entered into a daily log.

**CAMPER NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_

1. Observable evidence of illness, injury, disability or communicable disease.

	ARRIVAL AT CAMP	COMMENTS	DEPARTURE	COMMENTS
TEMPERATURE				
HEIGHT				
WEIGHT				
HAIR				
SKIN, (INC FEET)				
EYES				
EARS				
NOSE				
THROAT				
TEETH				
POSTURE				
	SIGNED		SIGNED	
	DATE		DATE	

2. Any changes to the Health History form since it was completed?

YES  NO

If yes, give details. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Any known exposure to communicable disease within last 2 weeks? If so, what? \_\_\_\_\_

\_\_\_\_\_

4. Record of medication \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Any follow up recommended by person conducting health screening? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Additional comments/observations. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_