



# HEALTH RECORD

CAMPERS: Return to:  
Robin Hull "Robin"  
3591 Kernan Blvd S #517  
Jacksonville FL 32224

STAFF: Return to:  
Jane Fenby "Auk"  
17001 Shady Pines Drive  
Lutz FL 33548

Exam yr \_\_\_\_\_  
Last yr \_\_\_\_\_  
WK 1 2 3 B

Year \_\_\_\_\_

Cabin \_\_\_\_\_

Name \_\_\_\_\_

No

Yes

Restrictions

No

Yes

Medical Issues

No

Yes

Medications

No

Yes

Allergies

## Personal Information

Name \_\_\_\_\_  
*Last First Middle Initial*

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_ Grade entering next term \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Home phone (\_\_\_\_\_) \_\_\_\_\_ Social Security number \_\_\_\_\_

Custodial parent/guardian \_\_\_\_\_ Relationship to camper \_\_\_\_\_

Home phone (\_\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_\_) \_\_\_\_\_

Family physician name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Family dentist name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

## Alternate Emergency Contact

Name \_\_\_\_\_ Relationship to camper \_\_\_\_\_

Home phone (\_\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_\_) \_\_\_\_\_

## Insurance Information

Name of insurance company \_\_\_\_\_

Telephone number \_\_\_\_\_

Address of insurance company \_\_\_\_\_

Policyholder's name \_\_\_\_\_ Identifying number \_\_\_\_\_

Relationship to camper \_\_\_\_\_ Group or policy number \_\_\_\_\_

Policyholder's date of birth \_\_\_\_\_ Social Security number \_\_\_\_\_

Land o' Sunshine Camp Cedarbrook carries secondary accident insurance, which means that the camp's insurance will only be used after an individual has filed with his/her own insurance company.

## Permissions

This health record is complete and accurate as far as I know. The person described in this record has permission to participate in all camp activities except as listed.

By signing below, I give permission to the camp to give me/my child routine health care, to distribute prescribed medications, and in an emergency, to seek medical treatment, including x-rays or routine tests. I give permission for the camp to provide transportation as necessary. I agree that any necessary medical records may be released for insurance purposes.

By signing below, I also give permission to the physician selected by the camp to secure and provide treatment, including admission to a hospital, for the person named above, if I cannot be reached by telephone in an emergency situation.

Signature of parent/guardian or staff member \_\_\_\_\_

Printed name \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of camper or staff member \_\_\_\_\_ Date \_\_\_\_\_

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

## Physical Examination by Licensed Medical Personnel

Name of camp participant \_\_\_\_\_

Examination date \_\_\_\_\_ (must be within 24 months of attending camp).

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Allergies \_\_\_\_\_

The above named individual is under the care of a physician for the following conditions:

\_\_\_\_\_

Continue the following treatment at camp:

\_\_\_\_\_  
\_\_\_\_\_

Limitations or restrictions on camp activities:

\_\_\_\_\_  
\_\_\_\_\_

List any additional information including medically-prescribed meal plan or dietary restrictions:

\_\_\_\_\_  
\_\_\_\_\_

### Administer the following medications at camp:

| Name of Medication | Dosage | Route | Frequency | Condition for which medication is prescribed | Comments |
|--------------------|--------|-------|-----------|--|----------|
|                    |        |       |           |  |          |
|                    |        |       |           |  |          |
|                    |        |       |           |  |          |

### List all immunization dates or attach the Florida HRS Certificate of Immunization Record.

| Vaccine                              | Date              | Date | Date | Date | Date | Date | Which of the following has the participant had?   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
|--------------------------------------|-------------------|------|------|------|------|------|---|---------------|-------------------|-------------------|-------------------|-------------|-------------------|----------------------|--|-----------------|--|-------------------------|--|--------------------------------------|--|
| DTP                                  |                   |      |      |      |      |      | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Measles _____</td> <td style="width: 50%;">Hepatitis A _____</td> </tr> <tr> <td>Chicken pox _____</td> <td>Hepatitis B _____</td> </tr> <tr> <td>Mumps _____</td> <td>Hepatitis C _____</td> </tr> <tr> <td>German measles _____</td> <td></td> </tr> <tr> <td colspan="2">TB Mantoux test</td> </tr> <tr> <td colspan="2">Date of last test _____</td> </tr> <tr> <td colspan="2">Result _____ Positive _____ Negative</td> </tr> </table> | Measles _____ | Hepatitis A _____ | Chicken pox _____ | Hepatitis B _____ | Mumps _____ | Hepatitis C _____ | German measles _____ |  | TB Mantoux test |  | Date of last test _____ |  | Result _____ Positive _____ Negative |  |
| Measles _____                        | Hepatitis A _____ |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| Chicken pox _____                    | Hepatitis B _____ |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| Mumps _____                          | Hepatitis C _____ |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| German measles _____                 |                   |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| TB Mantoux test                      |                   |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| Date of last test _____              |                   |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| Result _____ Positive _____ Negative |                   |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| TD                                   |                   |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| Tetanus                              |                   |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| Polio                                |                   |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| MMR                                  |                   |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| Or Measles                           |                   |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| Or Mumps                             |                   |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| Or Rubella                           |                   |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| Haemophilus Influenza B              |                   |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| Hepatitis B                          |                   |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |
| Varicella (chicken pox)              |                   |      |      |      |      |      |   |               |                   |                   |                   |             |                   |                      |  |                 |  |                         |  |                                      |  |

In my opinion, the above named individual is able to participate in an active camp program, with any restrictions or limitations listed above:  Yes  No

Signature of licensed medical personnel \_\_\_\_\_

Printed name \_\_\_\_\_

Address \_\_\_\_\_

Phone number (\_\_\_\_\_) \_\_\_\_\_ Date \_\_\_\_\_

## Health History

**Allergies:** List all allergies including medications, food, insect stings, hay fever, asthma, animal dander, etc.

|  |                              |  |
|--|------------------------------|--|
| <b>Camper/staff member is allergic to:</b> | <b>Describe the reaction</b> | <b>Describe the management of the reaction</b> |
|--|------------------------------|--|

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### Dietary Restrictions

### Activity Restrictions

|       |       |
|-------|-------|
| <hr/> | <hr/> |
| <hr/> | <hr/> |

Medications – list all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Bring medication in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration. Our camp nurse has common over-the-counter medications and these do not need to be sent to camp (i.e. Tylenol, Motrin, etc.).

**All medications must be turned in on arrival.**

**NO MEDICATIONS ARE TO BE KEPT IN THE CABINS WITH CAMPERS UNLESS FIRST CLEARED.**

| Name of Medication | Dosage | Route | Frequency | Condition for which medication is prescribed | Comments |
|--------------------|--------|-------|-----------|--|----------|
|                    |        |       |           |  |          |
|                    |        |       |           |  |          |
|                    |        |       |           |  |          |
|                    |        |       |           |  |          |

**General Health Questions** Check any conditions which the camper/staff member has now or has had and explain below.

|   |   |  |
|---|---|--|
| <input type="checkbox"/> Recent injury, illness or infectious           | <input type="checkbox"/> Chronic or recurring illness/condition     | <input type="checkbox"/> Hospitalizations or surgeries                                 |
| <input type="checkbox"/> Frequent or current ear infection              | <input type="checkbox"/> Diabetes                                   | <input type="checkbox"/> Back problems   |
| <input type="checkbox"/> Mononucleosis in the past 12 months            | <input type="checkbox"/> Seizures                                   | <input type="checkbox"/> Problems with joints (e.g. knees, ankles)                     |
| <input type="checkbox"/> Knocked unconscious                            | <input type="checkbox"/> Asthma                                     | <input type="checkbox"/> Fractures/sprains/strains                                     |
| <input type="checkbox"/> Head injury                                    | <input type="checkbox"/> High blood pressure                        | <input type="checkbox"/> Problems with diarrhea or constipation                        |
| <input type="checkbox"/> Frequent headaches                             | <input type="checkbox"/> Heart murmur                               | <input type="checkbox"/> Problems with sleepwalking                                    |
| <input type="checkbox"/> Chest pain during/after exercise               | <input type="checkbox"/> Skin problems (e.g. itching, rash, acne)   | <input type="checkbox"/> History of bed wetting  |
| <input type="checkbox"/> Passed out/dizzy during/after exercise         | <input type="checkbox"/> Abnormal menstrual history (if female)     | <input type="checkbox"/> Eating disorder   |
| <input type="checkbox"/> Wears glasses, contacts or protective eye wear | <input type="checkbox"/> Orthopedic appliance being brought to camp | <input type="checkbox"/> Emotional difficulties for which professional help was sought |

Explanation of checked conditions:

Use this space to provide any additional information about the camper's or staff member's behavior and physical, emotional, or mental health about which the camp should be aware.

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## Screening Record (For Camp Use Only)

**Initial Screening of** \_\_\_\_\_ **Date of arrival at camp** \_\_\_\_\_

General condition upon arrival to camp \_\_\_\_\_

|   | No                       | Yes                      | <i>If yes, please list specifics:</i> |
|---|--------------------------|--------------------------|---------------------------------------|
| Any recent exposure to communicable disease?        | <input type="checkbox"/> | <input type="checkbox"/> | _____                                 |
| Any recent cold, sore throat, or ear infection?     | <input type="checkbox"/> | <input type="checkbox"/> | _____                                 |
| Any recent injuries, such as abrasions, cuts, etc.? | <input type="checkbox"/> | <input type="checkbox"/> | _____                                 |
| Any contraindications to camp activity?             | <input type="checkbox"/> | <input type="checkbox"/> | _____                                 |

Any other information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Physical Examination Screening

**Throat Check: Result**    Negative    Positive

If positive, list action taken: \_\_\_\_\_  
 \_\_\_\_\_

**Lice Check: Result**    Negative    Positive

If positive, list action taken: \_\_\_\_\_  
 \_\_\_\_\_

### Medical Review

Regular or PRN medications indicated on Health Record?    No    Yes *(If yes, list on medication sheet)*

Medications received?    No    Yes   *If yes, medications secured in infirmary*    Yes

List any further information regarding medications: \_\_\_\_\_  
 \_\_\_\_\_

### Health Record Review

|   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| Any limitations of activities advised? Place on list to counselor .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies listed? If yes, circle in red and note on medication sheet .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Place food and other allergies on list to counselor                                       |                          |                          |
| Medical history completed within past 6 months and signed by parent/guardian .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| Immunization history complete .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| All other sections of the Health Record are complete .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Physician's signature present on a physical dated within the past 24 months? .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| Physician's address and phone number listed on physical? .....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Signature of parent' guardian or staff member giving consent for medical treatment? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Signature of camper/staff member agreeing to abide by restrictions on activity? .....     | <input type="checkbox"/> | <input type="checkbox"/> |

### Camp Health Care Personnel Signature

I have screened the above person and reviewed the Health Record on this date.

Signature/Title: \_\_\_\_\_ Date: \_\_\_\_\_