



ABCRM Front Range Camping
 at Quaker Ridge Camp
 July 11-17, 2010

**Health and Examination Form
 for Children and Youth attending Camp**

Mail this form to the address below by
June 21, 2010:
 ABC of the Rocky Mountains
 Front Range Camping
 6855 S. Havana St., Suite 220
 Centennial, CO 80112

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Parents/guardians of minors must fill out this form. Update required annually. Health exam (page 4) must be completed by approved licensed medical personnel at least every two years. **Please print legibly.**

CAMPER

Last Name: _____ First Name: _____ MI: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____ / ____ / ____ Gender: Male Female

Parent's Name: _____ Home Phone: () _____

Cell Phone: () _____ Work Phone: () _____

EMERGENCY CONTACT (in case parent cannot be reached):

Last Name: _____ First Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Relationship to Camper: _____ Home Phone: () _____

Cell Phone: () _____ Work Phone: () _____

HEALTH INSURANCE INFORMATION

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

Insured Member's Name: _____

Carrier's Name: _____ Plan Name: _____

Phone: () _____

Group #: _____ Member ID #: _____

HEALTH HISTORY

The following information must be filled in by the parent or guardian. The intent of this information is to provide camp personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participants arrival in camp. Provide complete information so that the camp can be aware of your needs.

Allergies: For Example: Hay Fever, Poison Ivy, Insect Stings, Penicillin, Other Drugs, Peanuts, Food or Animals:

Allergy — list below	Detailed Description	Medication Required

Medications: Yes, this person takes medications * No, this person does not take medications

* *If yes, please complete the Medications Form (page 3)*

GENERAL QUESTIONS (please explain "yes" answers below)

Has/does the participant:

	Yes	No		Yes	No
Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had problems with joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Have Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	Had problems with diarrhea or constipation?	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
Ever passed out during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>			
Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			
Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers. Use additional paper if necessary.

IMMUNIZATION: a copy of the participants immunization record MUST be attached/included with this form.

Physician's Name: _____ Phone: () _____

Dentist's Name _____ Phone: () _____

This health history is correct and complete as far as I know. The person herein described has my express consent to participate in all camp activities, including transportation by bus or mini-bus, except as noted. By giving this consent, I expressly acknowledge that I have been made aware that my child may be exposed to the risks of nature and of the elements over which neither the American Baptist Churches of the Rocky Mountains (ABCRM)/Camp nor its employees have control. Having been informed of such risks, I specifically agree that my child may participate in the program. This completed form may be photocopied for trips out of camp.

I hereby give permission to the physician selected by the camp director to order X-rays, routine tests, treatment, and emergency transportation for the health of my child. I hereby give permission to release the results of any of the aforementioned tests or treatment to the Camp and ABCRM. In the event I cannot be reached in an emergency, I hereby give permission to the physician or medical facility selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named on this form.

I accept responsibility for medical/surgical treatment charges which may be incurred on my child's behalf. I accept responsibility for the cost of any prescriptions and/or related expenses for my child's care and understand I will be billed by the ABCRM office.

Signature of Parent or Guardian: _____

Printed Name: _____ Date: _____

MEDICATIONS FORM

Please list all current medications your child is currently taking. **All medications must be in their original packaging that lists the prescribing physician an instructions.**

1. Name of Medication: _____ Dosage: _____
Specific times to be given: _____
Instructions: _____

Physician: _____
Is camper bringing this medication to camp? Yes No

2. Name of Medication: _____ Dosage: _____
Specific times to be given: _____
Instructions: _____

Physician: _____
Is camper bringing this medication to camp? Yes No

3. Name of Medication: _____ Dosage: _____
Specific times to be given: _____
Instructions: _____

Physician: _____
Is camper bringing this medication to camp? Yes No

4. Name of Medication: _____ Dosage: _____
Specific times to be given: _____
Instructions: _____

Physician: _____
Is camper bringing this medication to camp? Yes No

Please use additional paper if necessary.

HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

TO BE FILLED OUT BY A LICENSED PHYSICIAN FOR ALL CHILDREN AND YOUTH CAMPERS. This examination should be performed within 24 months of the date camper will **leave** camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Code: V — *Satisfactory* X — *Not Satisfactory (explain)* O — *Not examined*

BP _____ Weight _____ Height _____

Eyes _____	Hernia _____	Allergy: (please specify) _____
Glasses _____	Extremities _____	_____
Ears _____	Including: _____	_____
Nose _____	Shoulder _____	_____
Throat _____	Knees _____	General Appraisal: _____
Heart _____	Ankles _____	_____
Genitalia _____	Feet _____	_____
Lungs _____	Posture (Spine) _____	_____
Abdomen _____	Skin _____	_____

FOR FEMALES

Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special considerations: _____

The camper is under the care of a physician for the following conditions: _____

Does camper have epilepsy? Yes No Does camper have diabetes? Yes No

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

Medically prescribed meal plan or dietary restrictions: _____

Any restrictions for: Swimming/Boating _____

Strenuous Activity _____

Other _____

Is the camper currently taking any prescribed medications? Yes, complete Medications Form (page 3) No

PHYSICIAN'S SIGNATURE REQUIRED

On the basis of your knowledge of the applicant, the applicant's medical history, the present physical examination of this applicant and your knowledge of the activities in which they will participate, do you feel this individual is able to participate in camp activities? Yes No

Physician' Printed Name: _____

Signature: _____ Date: _____

Address: _____ Phone: () _____