

CAMP CAYUGA'S HEALTH EXAMINATION FORM

The camper's parent (or staff member) completes pages 1,2,3. The Examining Licensed Provider completes page 4.
Please print all information. Keep a copy of this form & notify the camp with any changes that occur.

RETURN THIS FORM AT LEAST 3 WEEKS BEFORE ARRIVAL:

(Before or on June 8th mail to): Camp Cayuga, PO Box 151, Peapack, NJ 07977, USA
(After June 8th mail to): Camp Cayuga, 321 Niles Pond Road, Honesdale, PA 18431, USA

Please staple a recent wallet-sized photograph here.

Print participant's first & last name on reverse side of photo.

Check box: Camper or Staff

Name: _____
Last Name First Middle

Birth date: _____. Age at camp: _____. Gender: Male, Female

Address: _____
Street City State Zip

Participant's phone: _____. Social security #: _____

NAME OF CUSTODIAL PARENT (1st person to contact): _____

Relationship to participant: Mother, Father, Guardian, Other (please describe): _____

Phone (home): _____. Phone (work): _____
(If different from participant)

Phone (cell): _____. Fax (home)(work): _____

Home address: _____
(If different from participant) Street City State Zip

NAME OF SECOND PARENT OR GUARDIAN (2nd person to contact): _____

Relationship to participant: Mother, Father, Guardian, Other (please describe): _____

Phone (home): _____. Phone (work): _____
(If different from participant)

Phone (cell): _____. Fax (home)(work): _____

Home address: _____
(If different from participant) Street City State Zip

NAME OF EMERGENCY CONTACT (3rd person to contact if parents are unreachable): _____

Relationship: _____. Phone (cell): _____

Phone (home): _____. Phone (work): _____

MEDICAL INSURANCE COVERAGE INFO: Attach copy (both sides) of your medical/prescription insurance card to the inside of this form.

Name of company: _____. Telephone: _____

Mailing address for claims: _____
Street City State Zip

Subscriber's name (primary card holder): _____

Subscriber's relationship to participant: Mother, Father, Guardian, Other (describe): _____

Subscriber's date of birth: _____. Subscriber's social security #: _____

Policy number (ID #): _____. Group number: _____

PERMISSION TO TREAT - SIGNATURE REQUIRED

I hereby give permission to the medical personnel (who have been selected by Camp Director) to: Administer over-the-counter and prescribed medications; order x-rays, routine tests, & treatment; release any records necessary for treatment and insurance purposes; and provide necessary related transportation for the person named above. In addition, if I cannot be reached in the event of an emergency, I give permission to the physician (selected by the Camp Director) to secure and administer treatment, including hospitalization, for said person above.

SIGNATURE OF PARENT/GUARDIAN OR STAFF MEMBER: _____

Print your name: _____. Date: _____

ENTRY#: _____
CABIN: _____
DIVISION: _____
SESSION: _____
FIRST NAME: _____
LAST NAME: _____

HEALTH HISTORY

The Health History section is completed by the camper's parent (or staff member). Afterwards, it's reviewed by the Examining Licensed Provider at the time of the health evaluation.

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:

- 1) Restriction from sports for a health related problem?..... Yes No
2) Injury, serious illness, or infectious disease within the past 12 months.....
3) Surgery, hospitalization, or emergency room visit(s)?.....
4) Chronic or ongoing illness or condition?.....
5) Physical, mental, or psychological conditions requiring medication, treatment, or special restrictions while at camp?.....
6) Anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders?.....
7) Diabetes?.....
8) Asthma?.....
If yes, do you have an inhaler? Yes, No.
Have other prescribed meds to control asthma? Yes, No.
9) Attention Deficit Hyperactivity Disorder (ADHD or ADD)?.....
10) Problems with sleepwalking?.....
11) History of bed-wetting?.....
12) History of motion sickness?.....
13) Eating disorder?.....
14) Problems with constipation or diarrhea?.....

EXPLAIN ALL "YES" ANSWERS HERE. INDICATE # OF QUESTION AND RELEVANT DATES.

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:

- 1) Concussion or head injury?..... Yes No
2) Memory loss?.....
3) Knocked out (unconscious)?.....
4) Seizure?.....
5) Frequent or severe headaches (with or without exercise)?.....
6) Fuzzy or blurry vision?.....
7) Sensitivity to light and/or noise?.....

EXPLAIN ALL "YES" ANSWERS HERE. INDICATE # OF QUESTION AND RELEVANT DATES.

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING GENERAL CONDITIONS:

- 1) Viral Infections (mono, hepatitis, coxsackie virus)?..... Yes No
2) Become tired more quickly than others?.....
3) Any of the following skin conditions? (check all that apply).....
cold sores/herpes, impetigo, MRSA (staph), ringworm, warts, sun sensitivity, acne, itching, rash.
4) Head lice/nits within past 60 days (including family members)?.....
5) Feelings of depression or emotional difficulties for which professional help was sought?.....
6) Heat-related problems? (check all that apply).....
dehydration, heat exhaustion, heat stroke, muscle cramps
7) Absence or loss of an organ?.....
8) Males: Any swelling or pain in testicles or groin?.....
9) Females: Age of onset of menstruation: _____

EXPLAIN ALL "YES" ANSWERS HERE. INDICATE # OF QUESTION AND RELEVANT DATES.

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING HEART-RELATED CONDITIONS:

- 1) Restriction from sports for heart problems?..... Yes No
2) Chest pain or discomfort?.....
3) Heart murmur?.....
4) High blood pressure?.....
5) Elevated cholesterol level?.....
6) Heart infection?.....
7) Dizziness or passing-out during or after exercise without known cause?.....
8) Has a medical provider ever ordered a heart test for you (EKG, stress test, echocardiogram, Holter monitor)?.....
9) Racing or skipped heartbeats?.....
10) Unexplained difficulty breathing or fatigue during exercise?.....

EXPLAIN ALL "YES" ANSWERS HERE. INDICATE # OF QUESTION AND RELEVANT DATES.

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING EYE, EAR, NOSE, MOUTH OR THROAT CONDITIONS:

- 1) Vision problems?..... Yes No
2) Wear? glasses, contacts, protective eye wear.....
(If yes, we recommend attaching a copy of the prescription.)
3) Hearing loss or problems?.....
If yes, wear? hearing aides, implants.
4) Ear infections?.....
5) Nasal fractures or frequent nose bleeds?.....
6) Wear an orthodontic appliance?.....
If yes, wear? braces, retainer, protective mouth gear.
Will the appliance/retainer be worn at camp? Yes, No.
7) Frequent strep throat or other throat conditions (tonsillitis)?.....

EXPLAIN ALL "YES" ANSWERS HERE. INDICATE # OF QUESTION AND RELEVANT DATES.

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING NEUROMUSCULAR OR ORTHOPEDIC CONDITIONS:

- 1) Numbness, a "stinger", a "burner", or pinched nerve?..... Yes No
2) A sprain or a strain?.....
3) Swelling or pain in muscles, tendons, bones, or joints?.....
4) Dislocated joint(s)?.....
5) Upper or lower back pain?.....
6) Fracture(s), stress fracture(s), or broken bone(s)?.....
7) Do you wear any protective braces or equipment?.....

EXPLAIN ALL "YES" ANSWERS HERE. INDICATE # OF QUESTION AND RELEVANT DATES.

MEDICATIONSCheck all boxes that apply:

- Participant is not currently taking any over-the-counter or prescription medication.
 Participant is currently taking over-the-counter and/or prescription medication. List name of med and describe purpose below.

MEDICATIONS CURRENTLY BEING TAKEN. List below all meds the participant is currently taking. The medications below do not serve as the list of meds the participant will bring to camp. All medications brought to camp are to be listed on the *Camp Medication Form* (not below).

Name of medication #1: _____ . Prescribed or Over-the-counter. Dosage: _____

Purpose: _____ . Frequency: _____

Name of medication #2: _____ . Prescribed or Over-the-counter. Dosage: _____

Purpose: _____ . Frequency: _____

Name of medication #3: _____ . Prescribed or Over-the-counter. Dosage: _____

Purpose: _____ . Frequency: _____

Name of medication #4: _____ . Prescribed or Over-the-counter. Dosage: _____

Purpose: _____ . Frequency: _____

needed. Attached is separate sheet listing more meds.

ALLERGIES & INTOLERANCESCheck all boxes that apply.

- Has no allergies. Has no intolerances/sensitivities to food.
 Has intolerances to: dairy, wheat, nuts, fish, shellfish,
 eggs, soy, other: _____

Medication is prescribed for food intolerance to: _____

- Has food allergy: dairy, wheat, nuts, fish, shellfish,
 eggs, soy, other foods: _____

Type of reaction to: (list food allergy) _____

- anaphylaxis, difficulty breathing, itchiness, hives, rash,

itchy/watery eyes, other: _____

Medication is prescribed for: (list food allergy) _____

EpiPen is prescribed for: (list food allergy) _____

Has allergy to medication: (list meds) _____

- Has other allergy: pollen, bee/insect stings, animal dander,
 latex, mold, other: _____

Type of reaction to: (list allergy) _____

- anaphylaxis, difficulty breathing, itchiness, hives, rash,

itchy/watery eyes, hay fever, other: _____

Medication is prescribed for: (list allergy) _____

EpiPen is prescribed for: (list allergy) _____

PHYSICIAN CONTACT

Please list the name & phone number of the camper's (or staff member's) medical providers.

Name: _____ . Phone: _____ . Family Doctor, Dentist, Orthodontist, Other.

Name: _____ . Phone: _____ . Family Doctor, Dentist, Orthodontist, Other.

ACTIVITY RESTRICTIONS The participant has restrictions and/or limitations to certain camp activities. List activities and explain below.

SIGNATURE REQUIRED

I completed the Health History section and provided accurate & complete information. I give the participant permission to engage in all camp activities except those indicated above. I agree to have the participant's scalp/hair examined for head lice by a trained professional before arrival. I agree to notify the camp if the participant is exposed to a communicable disease within 2 weeks of the participant's scheduled arrival in camp. I agree to notify the camp of any changes to this form after it's mailed to the camp.

Signature of parent/guardian (or staff member): _____ . Date: _____

SIGNATURE REQUIRED

I give Camp Cayuga permission to provide my credit card information to outside medical providers who render treatment/services to the participant. I authorize the use of my credit card for payment of charges incurred by the participant if they are not covered under my medical insurance plan (deductible, copay, etc). I do not authorize the use of my credit card for any other reason.

Check type of card: Visa, MasterCard. Account #: _____ . Expires: _____

Name on card (print): _____ . Signature of card holder: _____

HEALTH HISTORY
(continued)**IMMUNIZATION RECORD** Immunization Record is attached.

Participant has had: Measles, German Measles, Chicken Pox,
 Mumps, Hepatitis A, Hepatitis B, Hepatitis C, _____

Indicate the 5 most recent immunization dates for each of the vaccines listed.

VACCINE	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year
DTaP (tetanus, diphtheria, pertussis)	_____	_____	_____	_____	_____
Tdap/Td booster	_____	_____	_____	_____	_____
Hib (haemophilus influenza B)	_____	_____	_____	_____	_____
HepA (hepatitis A vaccine)	_____	_____	_____	_____	_____
HepB (hepatitis B vaccine)	_____	_____	_____	_____	_____
Flu (influenza)	_____	_____	_____	_____	_____
H1N1 (swine flu)	_____	_____	_____	_____	_____
IPV (polio)	_____	_____	_____	_____	_____
MMR (measles, mumps, rubella)	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____
MMRV (mmr&varicella)	_____	_____	_____	_____	_____
MCV4-MPSV4 (meningococcal)	_____	_____	_____	_____	_____
PCV-PPSV (pneumococcal)	_____	_____	_____	_____	_____
TB Test? (PPD, mantoux)	_____	_____	_____	_____	_____

DIETARY RESTRICTIONSCheck all boxes that apply.

- Has no dietary restrictions. Does have dietary restrictions.
 vegetarian, vegan, lactose intolerant, gluten intolerant, no yeast,
 celiac disease, no red meat, no pork, no poultry, no shellfish,
 no fish, no dairy, no milk, no eggs, no nuts, no seeds, no sugar,
 other: _____

HEALTH EVALUATION FORM

This form (page 4) is completed by the Examining Licensed Provider.

 Yes, No. Was a physical examination given within 12 month's of the camper's scheduled arrival? (For staff, it's 24 months.)

If yes, what was the date of the last exam)? _____ . Must attach a copy of the exam results.

If no, a physical examination is required before his/her scheduled arrival in camp. Complete this form in its entirety.

PHYSICAL EXAM RESULTSComplete this section if a physical exam has not been given within 12 months of the camper's scheduled arrival (or 24 months for staff). If an exam was given within this time period, do not complete this section if you attach a copy of the last exam results .

Height _____ .

Weight: _____ .

Blood Pressure: _____ / _____ .

Pulse: _____ bpm.

Vision: R 20/ _____ . L 20/ _____ .

Corrected? Yes, No.Contacts? Yes, No.Glasses? Yes, No.

	NORMAL? (circle)		NORMAL? (circle)		NORMAL? (circle)
INDICATORS		INDICATORS		INDICATORS	
1) General Appearance.....	Yes..	8) Femoral Pulses.....	Yes..	16) Neck/Back/Spine: Range of motion.....	Yes..
2) Head/Neck.....	Yes..	9) Lungs: (auscultation/percussion)...	Yes..	Scoliosis.....	Yes..
3) Eyes: (sclera/pupils).....	Yes..	10) Chest Contour.....	Yes..	17) Upper Extremities: (ROM, strength, stability).....	Yes..
4) Ears: (gross hearing).....	Yes..	11) Skin.....	Yes..	18) Lower Extremities: (ROM, strength, stability).....	Yes..
5) Nose/Mouth/Throat.....	Yes..	12) Abdomen: (liver,spleen,masses) ..	Yes..	19) Neurological: (balance & coordination)	Yes..
6) Lymph Glands.....	Yes..	13) Assessment of physical maturation or Tanner Scale....	Yes..	20) Evid. of Marfan Syndrome..	Absent
7) Heart: Rate.....	Yes..	14) Testicular Exam (males only) ...	Yes..		
	Yes..	15) Hernia.....	Absent		
	Absent				

 Explain each answer above that was not circled as "yes": _____**BASED UPON THE EXAMINATION COMPLETED WITHIN THE PAST 12 MONTHS (24 months for staff):** Check all boxes that apply. Camper/staff is cleared for participation in all activities without restriction. Camper/staff is cleared for participation in limited types of activities which exclude the following types of sports: contact, limited contact, non-contact/strenuous, non-contact/non-strenuous.

Describe restriction: _____

 Camper/staff is withheld clearance for participation in any sport until evaluation of: _____ Yes, No. Is participant under the care of a physician? Please explain below. Yes, No. Is participant receiving current or on-going treatment or medications? Please explain below.

Explanation: _____

 Yes, No. I reviewed the Health History Section. No revisions. Revisions noted.

Additional Observations regarding participant's behavior, and physical, emotional and/or mental health: _____

General Diagnosis/Recommendations: _____

EXAMINING PROVIDER'S CONTACT INFORMATION

(Use ink stamp here or print requested information below.)

Name:

Address:

City:

State:

Zip:

Phone:

SIGNATURE REQUIRED

Medical Provider's Signature: _____

License Type: MD/DO, APN, PA. Date signed: _____

Date this Evaluation Form was completed: _____