

# CAMP CAYUGA'S HEALTH EXAMINATION FORM

Please complete pages 1,2,3. The Examining Licensed Provider completes page 4.  
Please print all information. Keep a copy of this form & notify the camp of changes, if any.

## RETURN THIS FORM AT LEAST 3 WEEKS BEFORE ARRIVAL:

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

Staple a recent wallet-sized photograph here.

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

Check One : The participant is a  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** (1<sup>st</sup> 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** (2<sup>nd</sup> 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** (3<sup>rd</sup> person to contact if parents are unreachable): \_\_\_\_\_

Relationship: \_\_\_\_\_. Phone (cell): \_\_\_\_\_

Phone (home): \_\_\_\_\_. Phone (work): \_\_\_\_\_

**MEDICAL INSURANCE COVERAGE INFORMATION:** 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 date of birth: \_\_\_\_\_

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

Policy 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:

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

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

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## HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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**MEDICATIONS**Check  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: \_\_\_\_\_

Attached is separate sheet listing more meds. needed.

**ALLERGIES & INTOLERANCES**Check  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 &amp; 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 by providing accurate & complete information. I give the participant permission to engage in all camp activities, unless otherwise indicated above. I ensure the participant's scalp/hair will be examined for head lice by a trained professional 2 weeks before arrival. I agree to notify the camp if the participant is exposed to a communicable disease within 2 weeks of arrival. I will inform the camp of changes, if any, to this form.

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. I understand this information will be kept secure by the camp.

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 RESTRICTIONS**Check  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 RESULTS

Complete 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 .

	NORMAL? (circle)	NORMAL? (circle)	NORMAL? (circle)
Height _____.			
Weight: _____.			
Blood Pressure: _____ / _____.			
Pulse: _____ bpm.			
Vision: R 20/_____. L 20/_____.			
Corrected? <input type="checkbox"/> Yes, <input type="checkbox"/> No.			
Contacts? <input type="checkbox"/> Yes, <input type="checkbox"/> No.			
Glasses? <input type="checkbox"/> Yes, <input type="checkbox"/> No.			
<b>INDICATORS</b>		<b>INDICATORS</b>	<b>INDICATORS</b>
1) General Appearance.....	Yes..	8) Femoral Pulses.....	Yes..
2) Head/Neck.....	Yes..	9) Lungs: (auscultation/percussion)...	Yes..
3) Eyes: (sclera/pupils).....	Yes..	10) Chest Contour.....	Yes..
4) Ears: (gross hearing).....	Yes..	11) Skin.....	Yes..
5) Nose/Mouth/Throat.....	Yes..	12) Abdomen: (liver,spleen,masses) ..	Yes..
6) Lymph Glands.....	Yes..	13) Assessment of physical maturation or Tanner Scale....	Yes..
7) Heart: Rate.....	Yes..	14) Testicular Exam (males only) ...	Yes..
	Rhythm.....	15) Hernia.....	Absent
	Murmur.....		Absent
	Absent		
		16) Neck/Back/Spine: Range of motion.....	Yes..
		Scoliosis.....	Yes..
		17) Upper Extremities: (ROM, strength, stability).....	Yes..
		18) Lower Extremities: (ROM, strength, stability).....	Yes..
		19) Neurological: (balance & coordination) .....	Yes..
		20) Evid. of Marfan Syndrome..	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: \_\_\_\_\_