



# CAMP ARROWHEAD HEALTH FORM 2012

P.O. BOX 625  
LEWES, DE 19958

SESSION \_\_\_\_\_

PROGRAM \_\_\_\_\_

Office  
Use  
Only

THE HEALTH FORM MUST BE COMPLETED AND SIGNED BY THE PARENT/GUARDIAN AND PHYSICIAN. COMPLETED FORMS MUST BE MAILED TO THE REGISTRAR BY MAY 15<sup>TH</sup>. ANY CHANGES TO THE HEALTH FORM MUST BE PRESENTED IN WRITING UPON ARRIVAL TO CAMP.

NAME \_\_\_\_\_

Male  Female  BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

CUSTODIAL PARENT/GUARDIAN \_\_\_\_\_

COMPLETE ADDRESS \_\_\_\_\_  
\_\_\_\_\_

HOME TELEPHONE \_\_\_\_\_ WORK TELEPHONE \_\_\_\_\_

CELL PHONES \_\_\_\_\_

EMERGENCY CONTACT IF CUSTODIAL PARENT/GUARDIAN IS NOT AVAILABLE, PLEASE NOTIFY:

1. Name \_\_\_\_\_ Telephone \_\_\_\_\_

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

2. Name \_\_\_\_\_ Telephone \_\_\_\_\_

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

**HEALTH AND ACCIDENT INSURANCE IS NOT PROVIDED FOR THE CAMPERS. CAMP ARROWHEAD CARRIES LIABILITY INSURANCE FOR INJURIES FOR WHICH THE CAMP IS RESPONSIBLE. FAMILY HOSPITAL AND MEDICAL INSURANCE COVERAGE FOR CAMPERS IS STRONGLY ADVISED. CHARGES NOT COVERED BY FAMILY INSURANCE WILL BE THE RESPONSIBILITY OF THE PARENT/GUARDIAN.**

Do you carry family Medical/hospital insurance? YES  NO  Prescription insurance? YES  NO

**PLEASE PROVIDE A FRONT AND BACK COPY OF INSURANCE AND PHARMACY CARDS AS WELL AS PROVIDING THE INFORMATION BELOW.**

Company Name \_\_\_\_\_

Name of person carrying insurance \_\_\_\_\_

Policy, group, and ID numbers \_\_\_\_\_

Mailing Address of Insurance company \_\_\_\_\_

Insurance company telephone numbers \_\_\_\_\_



**IMMUNIZATION HISTORY** (Required immunizations are determined locally)

DPT1	DPT2	DPT3	DPT4	DPT5	Td booster
IPV1	IPV2	IPV3	IPV4	IPV5	
MMR1	MMR2		VARICELLA1	VARICELLA2	
HIB1	HIB2	HIB3	HIB4	HIB5	
HBV1	HBV2	HBV3	OTHER:		
HepA1	HepA2	TB Mantoux Test: Date of last test _____ Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/>			

**MEDICATIONS**

Does your camper take prescription or over-the-counter medications regularly? YES  NO

Will the medications be brought to camp either for daily use or as needed use? YES  NO

**PLEASE NOTE: ALL MEDICATIONS MUST BE IN THEIR ORIGINAL CONTAINERS OR PACKAGING. NO EXCEPTIONS!**

**Please list all medications (including over-the-counter or non-prescription drugs) taken routinely. Include the name of the medication, the dosage, and the hour the medication is usually given.**

Medication	Dosage	Hour given

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

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**PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE:**  
 This health history is correct so far as I know and the person herein described has permission to engage in all prescribed camp activities, except as noted by me. \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT:** I hereby give permission to the medical personnel selected by the Diocese of Delaware to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Diocese of Delaware to secure and administer treatment, including hospitalization, for the person named above. The completed form may be photocopied for trips out of camp.

Signature \_\_\_\_\_ Date \_\_\_\_\_



# Medical Evaluation

*The Medical evaluation should be completed by a licensed physician, nurse practitioner or physician's assistant and can be based on an examination completed within the last 24 months.*

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Male  Female  Date of Physical Examination \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

*I have reviewed the health history of the person herein described. It is my opinion that he/she is physically able to engage in camp activities, except as noted.*

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

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Physician's Name \_\_\_\_\_

Office Telephone \_\_\_\_\_

Address \_\_\_\_\_

**For camp use only:**

Updates/additions to health history noted	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> None required
Any injuries or current illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Date \_\_\_\_\_ Time \_\_\_\_\_ am/pm Meds received:  Yes  No

Current health needs identified: \_\_\_\_\_

Head Check:  Yes  No \_\_\_\_\_ Foot Check:  Yes  No \_\_\_\_\_ Skin Check:  Yes  No \_\_\_\_\_

Observational notes: \_\_\_\_\_

Screened by \_\_\_\_\_