



New England Frontier Camp Adult Health History Form

197 Quite A Road, Lovell, ME 04051 Tel: 207-925-6735 Fax: 207-925-1141

Year:	2004

Personal Information

Name _____ Birth date _____ Age _____
 Address _____ Social Security # _____
 City, State, Zip Code _____

Emergency Contact

Parents Spouse _____ Phone _____
 Address (if different from above) _____
 Business Address _____ Phone _____
 Business Address _____ Phone _____
 If not available in an emergency, please notify: _____ Relationship _____
 Address _____ Phone _____

Family Medical Information

Name of family physician _____ Phone _____
 Name of family dentist / orthodontist _____ Phone _____

Insurance Information

Insurance plan name _____ Subscriber ID # _____
 Insurance Plan Phone # _____
 Subscriber _____ Relationship to camper _____

Prescription Information (Please complete if different from above.)

Insurance plan name _____ Group # _____
 Carrier Address _____
 Name of Insured _____ Social Security / insurance ID number _____

Permission to Treat

In the event that I require medical care during my involvement at New England Frontier Camp, I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order X-rays, routine test, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me. In the even that I am incapacitated, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for myself.

This form may be photocopied for use out of camp

Signature of adult camper or staff member

Date

For camp health care staff use

Screened by _____ Date _____ Time _____ Updates / additions yes no
 Screened by _____ Date _____ Time _____ Updates / additions yes no
 Screened by _____ Date _____ Time _____ Updates / additions yes no
 Screened by _____ Date _____ Time _____ Updates / additions yes no

Health History

The intent of this information is to provide camp health care personnel the background to provide appropriate care. Provide complete information so we can be aware of your needs. **Keep a copy of this form for your records.** Check all that apply and comment below.

<input type="checkbox"/> Frequent ear infections <input type="checkbox"/> Heart defect / disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Seizures <input type="checkbox"/> Bleeding / clotting disorders <input type="checkbox"/> Skin disorders (itching, rash, acne...) <input type="checkbox"/> Hives <input type="checkbox"/> Mononucleosis <input type="checkbox"/> HIV positive <input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma <input type="checkbox"/> Head injury <input type="checkbox"/> Dizziness, unconsciousness, or chest pain after exercise <input type="checkbox"/> Back problems <input type="checkbox"/> Joint problems (e.g. knees, ankles) <input type="checkbox"/> Cancer <input type="checkbox"/> Sleepwalking <input type="checkbox"/> Glasses / contact lenses <input type="checkbox"/> Orthodontic appliance	Known Allergies <input type="checkbox"/> Bee / insect stings <input type="checkbox"/> Medications <input type="checkbox"/> Food <input type="checkbox"/> Poison ivy / environmental <input type="checkbox"/> Describe reaction and management to the reaction: _____ _____
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Please comment on any of the above

Immunization History	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	The participant has had...
DPT*	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Measles
TD* (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Chicken pox
Tetanus*	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> German Measles
Polio	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Mumps
MMR	_____	_____	_____	_____	_____	_____	Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B
Hepatitis-A	_____	_____	_____	_____	_____	_____	TB Mantoux or PPD
Hepatitis-B (HBV}	_____	_____	_____	_____	_____	_____	Date of last test _____
Varicella (chicken pox)	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative

*Tetanus must be within 10 years of camp

Medications

I take NO medications on a routine basis I takes medications as listed below

Please list all prescription and non-prescription medications your son will be bringing to camp. List only those medications which he will be taking at camp time. **Prescription medications** must be **IN THE ORIGINAL CONTAINER** with **doctor's instructions clearly indicated**. All medications will be stored in the camp Health Center and administered by the camp health care personnel.

Medication (e.g. Penicillin)	Dosage / Frequency (e.g. 250mg three times daily)	Reason for taking (e.g. Strep Throat)	For camp health care staff use

Health Care Recommendations by Licensed Medical Personnel

A health examination by licensed medical personnel is not required, but is *highly encouraged* at least every two years.

Date of last examination _____ BP _____ Weight _____ Height _____ In my opinion, the above applicant <input type="checkbox"/> is <input type="checkbox"/> is not able to participate in an active camp program. The applicant is under the care of a physician for the following condition(s): _____ _____ Current treatment at the time of this report: _____ _____	<p>Recommendations and restrictions at camp</p> Treatment to be continued at camp: _____ _____ Medications to be administered at camp (name, dosage, frequency): _____ _____ Known allergies: _____ _____ Additional information for health care staff of the camp: _____ _____
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Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Date of form completion _____ Phone _____