



Higher Ground Encampment Health Forms

To be filled out by Campers Parent/legal Guardian or Adult Staff Member

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Name:

Last _____ First _____ M.I. _____

Birth Date _____ Age _____

Fathers/Guardian's Last Name _____ Phone (____) _____

Home Address _____

Business Address _____

Mother's/Guardian's Last Name _____ Phone (____) _____

Home Address _____

Business Address _____

If not available during an emergency, notify:

Name: _____ Relationship _____

Phone (____) _____ Work Phone (____) _____

Address _____

Health History

Check all that apply giving approximate dates:

| | | | |
|-------------------------------|--|-----------------------------------|---------------------|
| Frequent Ear Infections _____ | Hearing Impairment _____ | Chicken Pox _____ | Allergies _____ |
| Eyesight Impairment _____ | Speech Impairment _____ | Measles _____ | Hay Fever _____ |
| Severe Menstrual Pain _____ | Intestinal Disorders _____ | German Measles _____ | Penicillin _____ |
| Blood Pressure Prob. _____ | Mental/Emotional Prob _____ | Mumps _____ | Aspirin _____ |
| Kidney Disease _____ | Heart Disease _____ | Hepatitis _____ | Insect Stings _____ |
| Rheumatic Fever _____ | Sinutitis _____ | Mononucleosis _____ | Other _____ |
| Diabetes _____ | Convulsions _____ | Bleeding/Clotting Disorders _____ | Arthritis _____ |
| Hypertension _____ | Other Drug Allergies/disease/conditions not listed above _____ | | |

Food or any other allergies not listed above? _____

Ever required psychiatric counseling or hospitalization? _____

Operations/serious injuries _____

Disability or chronic/reoccurring illness: _____

Any specific activities to be encouraged or limited by physicians advice? _____

Dietary Modifications: _____

Current Medications: (sent with instructions) (By Colorado Law, all prescriptions other than inhalers must be kept by the camp medical staff) _____

Has this female camper ever menstruated? _____ If not, has she been told to expect it? _____

Is menstrual history normal? _____ Special considerations? _____



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Immunization History

| Vaccines | Year of Basic Immunization | Year of Last Booster |
|--|-----------------------------------|-----------------------------|
| Diphtheria | | |
| Pertussis | | |
| Tetanus | | |
| Tetanus TD | | |
| Oral Polio (Sabin) TOPV | | |
| Injectable Polio (Salk) | | |
| Measles (Hard Measles, Red Measles, Rubeola) | | |
| Mumps | | |
| Rubella (German Measles, 3-Day Measles) | | |
| Other | | |

Name of Physician or PCP: _____ Phone (____) _____
 Address _____
 Name of dentist/orthodontist _____
 Date of last physical examination _____

Your medical history is primary. Please give carrier of family medical/hospital insurance _____
 Policy and or Group # _____ Phone(____) _____
 HMO or PPO? _____ Address where claims can be sent _____

This health history is correct as far as I know, and the camper/staff member listed above has permission to engage in all prescribed camp activities except as noted. I hereby give permission to HG Encampment (1) To provide ongoing health care (2) To select medical personnel and to order routine X-rays or routine tests or treatment for the camper/staff member (3) In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to hospitalize, secure proper treatment for and to order injections/anesthesia/surgery for the camper/staff person named above. This form may be photocopied for use by Higher Ground Encampment.

Parent Legal Guardian / Adult Staffer Signature _____
 Witness Signature _____ Date _____
 I understand and agree to abide with the restrictions placed on my camp activities
 Camper's Signature _____



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Higher Ground Encampment Physical Form

Health Examination by Licensed Physician Date Examined _____

To be filled in by a licensed physician within one year of the camp date. By Colorado Law, failure to bring this record to camp will prohibit the camper's / staff member's enrollment.

Name _____ Height _____ Weight _____ Blood Pressure _____

The applicant is under the care of a physician for the following conditions(s): _____

Significant History _____

Medications _____

Allergies _____

Any medically prescribed meal plan or dietary restrictions: _____

I have examined the above named camp applicant. In my opinion, the above's condition does _____ or does not _____ preclude her participation in an active camp program.

Licensed Physician's Signature: _____ Date: _____

Typewritten or Printed name: _____

Address _____ Phone(_____) _____