# Health and Medical Form

This form must be completed in order for campers and staff to attend camp

**Please Mail or Fax to:**
**Pine Brook Camp**
210 Lakeview Road
Shutesbury, MA 01072
Phone: (413) 367-2643
FAX: (413) 367-2140

## GENERAL INFORMATION

**Name** ______________________ Birth Date ____/____/____ Age ________ ☐ Male ☐ Female

Address ______________________ Phone ______________

City ______________ State ________ Zip ________ Grade completed (youth only) ________

**Mother** (or Guardian) ______________ Work No. ______________ Cell No. ______________

**Father** (or Guardian) ______________ Work No. ______________ Cell No. ______________

**Emergency Contact – If a parent is not available, please notify:**

Name ______________ Relation______________ Cell No. ______________

Address ______________________ Phone No. ______________

**Insurance Company** ______________________ Policy Number ______________

Family Physician ______________________ Phone No. ______________

Dentist/orthodontist ______________________ Phone No. ______________

## MEDICAL HISTORY

Are you now, or have you ever been treated for any of the following:

| Y | N | Condition | Explain | Y | N | Condition | Explain |
|---|---|---|---|---|---|---|---|
| | | Asthma | | | | Sickle cell disease | |
| | | Diabetes | | | | Kidney disease | |
| | | Hypertension (high blood pressure) | | | | Fainting spells | |
| | | Heart disease (CHF, CAD, MI) | | | | Sleep disorders (sleep apnea) | |
| | | Stroke/TIA | | | | GI problems (abdominal, digestive) | |
| | | COPD | | | | Surgery | |
| | | Ear/sinus problems | | | | Serious Injury | |
| | | Psychiatric/psychological disorders | | | | Chicken Pox | |
| | | Emotional difficulties | | | | Measles | |
| | | Learning disorders (ADHD, ADD) | | | | Mumps | |
| | | Bleeding disorders | | | | Seizures | |
| | | Thyroid disease | | | | Allergies | |

PLEASE LIST ANY **MEDICATION** NEEDED TO BE TAKEN WHILE AT CAMP (A **MEDICATION RECORD FORM** must be filled out on registration day)

______________________ ______________________

______________________ ______________________

PLEASE LIST ANY **FOOD ALLERGIES**: ______________________

______________________________________________

**PARENT SIGNATURE REQUIRED**

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. **Authorization for Treatment**: I hereby give permission for the camp nurse to administer medications and treatment for my child as named above, including non-prescription medications for mild illness as well as the prescriptions brought with the child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, and to order injections, anesthesia or surgery for my child as named above.

______________________ ______________

Signature of parent or guardian or adult camper or staff — Date

## IMMUNIZATION HISTORY

*Written documentation of immunization or alternative proof of immunity is required for all campers and staff members. Please fill in the chart below or attach a copy of all immunizations.*

| vaccine | | Date/type | Vaccine | | Date/type | Vaccine | | Date/type | Vaccine | | Date/type |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Hepatitis B** (HepB, HepB-Hib, DTaP-HepB-IPV) | 1 | | **Haemophilus influenzae type b** (Hib, HepB-Hib, DTaP-Hib) | 1 | | **Polio** (IPV, DTaP-HepB-IPV) | 1 | | **Pneumococcal Polysaccharide** | 1 | |
| | 2 | | | 2 | | | 2 | | | 2 | |
| | 3 | | | 3 | | | 3 | | **Influenza** Inactivated (Intramuscular) or | 1 | |
| **Diptheria, Tetanus, Pertussis** (DTaP, DT, DTaP-Hib, Dtap-HepB-IPV,Td | 1 | | | 4 | | | 4 | | | 2 | |
| | 2 | | **Measles, Mumps** | 1 | | **Pneumococcal Conjugate** (PCV7) | 1 | | | 3 | |
| | 3 | | | 2 | | | 2 | | **Other:** | | |
| | 4 | | **Varicella** (var) | 1 | | | 3 | | | | |
| | 5 | | | 2 | | | 4 | | | | |
| | 6 | | **Hepatitis A** (HepA) | 1 | | | | | | | |
| | 7 | | | 2 | | | | | | | |

************Medical Examination to be completed by a license physician************

## MEDICAL EXAMINATION

*This examination should be performed within 24 months of arrival at camp. Examination for some other purpose within this period is acceptable. (If camper or staff has had an exam within* ***24 months of camp****, attach a copy of that exam to this form, or bring it with you to camp on registration day). Examination is for determining fitness to engage in strenuous activities.*

Blood Pressure:__________________________ Pulse:____________________________

| | Normal | Abnormal | Explain any abnormalities | Range of Mobility | Normal | Abnormal | Explain any abnormalities |
|---|---|---|---|---|---|---|---|
| Eyes | | | | Knees (both) | | | |
| Ears | | | | Ankles (both) | | | |
| Nose | | | | Spine | | | |
| Throat | | | | | | | |
| Lungs | | | | **Other** | **Yes** | **No** | |
| Heart | | | | Contacts | | | |
| Abdomen | | | | Dentures | | | |
| Genitalia | | | | Braces | | | |
| Skin | | | | Inguinal hernia | | | **Explain** |
| Emotional adjustment | | | | Medical Equipment (i.e., CPAP, oxygen) | | | |

## RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

Special Needs to be considered ____________________________________________

Restrictions __________________________________________________

Other______________________________________________________

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

________________________________ ____________________

Licensed Physician's Signature Date

Address____________________________________

____________________________________ Phone____________________