

# Camp Stewart for Boys

## Health History & Examination Form

Adapted from form developed by American Camp Association, American Academy of Pediatrics Council on School Health & Association of Camp Nurses

**To Parent(s)/Guardian(s):** Please follow the instructions below. *Attach additional information if needed*

- 1) Complete pages 1, 2 and 3 of this form and give it to your child's health-care provider for review & completion of page 4.
- 2) Texas law requires a complete medical history on all campers and staff.

**Medical Insurance Information:** Attach copy of both sides of your insurance card AND pharmacy card

This camper is covered by family medical/hospital insurance Yes No

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Subscriber \_\_\_\_\_ Insurance Company Phone Number (\_\_\_\_) \_\_\_\_\_

Pharmacy Card Yes No Card ID# \_\_\_\_\_ Type Pharmacy Card \_\_\_\_\_

Pharmacy card may be used at Rexall CVS Walgreen Wal-mart Other \_\_\_\_\_

**Camper Home Address** \_\_\_\_\_  
Street Address City State Zip

Parent/Guardian with legal custody to be contacted in case of illness or injury:

Name \_\_\_\_\_ Relationship to camper \_\_\_\_\_ Preferred Phones (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Home Address \_\_\_\_\_  
*(if different from above)* street address city state zip

Second parent/guardian or other emergency contact:

Name \_\_\_\_\_ Relationship to camper \_\_\_\_\_ Preferred Phones (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Additional contact in event parent(s)/guardian cannot be reached:

Name \_\_\_\_\_ Relationship to camper \_\_\_\_\_ Preferred Phones (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

**Allergies** No known allergies This camper is allergic to Food Medicine The environment (insect stings, hay fever, etc.) Other  
*(Please describe below what the camper is allergic to and the reaction seen).*

**Diet, Nutrition** This camper eats a regular diet This camper has special food needs (Please describe below)

**Restrictions** I have reviewed the program and activities of the camp and feel my camper can participate without restrictions.  
I have reviewed the program and activities of the camp and feel my camper can participate with the following restrictions or adaptations.  
(Please describe below).

**Parent/Guardian Authorization for Health Care:**

This health history is correct and accurately reflects the health status of my camper. He has permission to participate in all camp activities except as noted by me and/or the examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for him. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. **In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the camp's staff about my child's health status.**

Signature of Custodial Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

**Camper Name** \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age on arrival at camp \_\_\_\_  
Month/day/year

**Dates Attending Stewart:** \_\_\_\_\_ to \_\_\_\_\_  
Month/day/year Month/day/year

When completed and signed by health-care provider, return to: **Camp Stewart for Boys**

**612 FM 1340  
Hunt, TX 78024**

at least 7 days prior to camp arrival OR bring on Opening Day & give to Camp Nurse.  
Do not send in camper's trunk or with camper!



**Immunization History:** Provide the month and year for each immunization. Starred (\*) immunizations must be current. Copies of immunization forms from health-care providers or others are acceptable: please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most recent Dose Month/Year
H1N1 (Swine Flu)*						
Diphtheria, tetanus, pertussis* (DTaP) or (TdaP)						
Tetanus booster* (dT) (TdaP)						
Mumps, measles, rubella* (MMR)						
Polio* (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella Had chicken pox (chicken pox) Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test      Date:      Negative      Positive

**If your camper has not been fully immunized, please sign the following statement:: *I understand and accept the risks to my child from not being fully immunized.***

Signature of Custodial Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

**Medication:** This camper will not take any daily medications while attending camp.

This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. **All medications must be in the original bottles with prescription label showing camper's name and how the medication should be given. Enough medication to last the entire time the camper will be at camp should be provided.**

Name of medication	Date started	Reason for taking it	When it is given	Amount of dose given	How it is given
			Breakfast Lunch Dinner Bedtime Other		
			Breakfast Lunch Dinner Bedtime Other		
			Breakfast Lunch Dinner Bedtime Other		

The following non-prescription medications may be stocked in the Infirmary and are used on an as needed basis to manage illness and injury. **Cross out those your camper should not be given.**

- |   |  |
|---|--|
| Acetaminophen (Tylenol)                                   | Guaifenesin cough syrup (Robitussin)                             |
| Phenylephrine decongestant (Sudafed PE)                   | Dextromethorphan cough syrup (Robitussin DM) Generic cough drops |
| Antihistamine/allergy medicine                            | Antibiotic cream   |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Aloe   |
| Sore throat spray   | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)    |
| Lice shampoo or cream (Nix or Elimite)                    |  |
| Calamine lotion   |  |
| Laxative for constipation (Ex-Lax)                        |  |
| Ibuprofen (Advil, Motrin)                                 |  |
| Pseudoephedrine decongestant (Sudafed)                    |  |

**General health history:** check “yes” or “No” for each statement. Explain “Yes” answers below.

Has/does camper:

- |  |     |    |   |     |    |
|--|-----|----|---|-----|----|
| 1. Ever been hospitalized?                         | Yes | No | 11. Had fainting or dizziness?                            | Yes | No |
| 2. Ever had surgery?                               | Yes | No | 12. Passed out/had chest pain during exercise?            | Yes | No |
| 3. Have recurrent/chronic illnesses?               | Yes | No | 13. Been diagnosed with a heart murmur?                   | Yes | No |
| 4. Had a recent infectious disease?                | Yes | No | 14. Had mononucleosis ('mono') during the past 12 months? | Yes | No |
| 5. Had a recent injury?                            | Yes | No | 15. Have problems with falling asleep/sleepwalking?       | Yes | No |
| 6. Had asthma/wheezing/shortness of breath?        | Yes | No | 16. Ever had back/joint problems?                         | Yes | No |
| 7. Have diabetes?                                  | Yes | No | 17. Have a history of bedwetting?                         | Yes | No |
| 8. Had seizures?                                   | Yes | No | 18. Have problems with diarrhea/constipation?             | Yes | No |
| 9. Had headaches?                                  | Yes | No | 19. Have any skin problems?                               | Yes | No |
| 10. Wear glasses, contacts, or protective eyewear? | Yes | No | 20. Traveled outside the country in the past 9 months?    | Yes | No |

**Please explain “Yes” answers in the space below**, noting the number of the question. For travel outside the country, please name the countries visited and dates of travel.

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**Mental, Emotional and Social Health:** check “yes” or “No” for each statement.

Has the camper:

- |   |     |    |
|---|-----|----|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? | Yes | No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?                          | Yes | No |
| 3. During the past 12 months seen a professional to address mental/emotional health concerns?                 | Yes | No |
| 4. Had a significant life event that continues to affect the camper's life?                                   | Yes | No |

*(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)*

**Please explain “Yes” answers in the space below**, noting the number of the questions. Stewart may contact you for additional information.

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**Health care providers:**

Name of camper's primary doctor(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of dentist(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of orthodontist(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

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**What have we forgotten to ask?** Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. **Attach additional information if needed.**

# Stewart Camper Health Care Recommendations by Licensed Medical Personnel

Mail this form to  
Camp Stewart for Boys  
612 FM 1340  
Hunt, TX 78024-3024

★ **Medical Personnel: Please review the Camper Health History Form and complete all sections of this form. Attach additional information if needed.** ★

Camper Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle Month day year

Physical exam done today Yes No If "No", date of last physical \_\_\_\_\_  
ACA accreditation standards specify physical exam within last 24 months.

Weight: \_\_\_ lbs Height \_\_\_ ft \_\_\_ in Blood Pressure \_\_\_ / \_\_\_ Pulse \_\_\_ Heart Rate \_\_\_\_\_

**Allergies:** No Known Allergies  
To foods (list)  
To medications (List)  
To the environment (insect stings, hay fever, etc. – list)  
Other allergies: (list)

**Describe previous reactions**

**Diet, Nutrition:** Eats a regular diet Has a medically prescribed meal plan or dietary restrictions: (describe below)

**This camper is undergoing treatment at this time for the following conditions:** (describe below) None

**Medication:** No daily medications Will take the following prescribed medication(s) while at camp: (name, dose, frequency-describe below)

**Other treatments/therapies to be continued at camp:** (describe below) None needed

Do you feel that the camper will require limitations or restrictions to activity while at camp? No Yes  
If you answered "Yes" to the question above, What do you recommend?  
(Describe below – attach additional information if needed)

**I have reviewed the CAMPER HEALTH HISTORY FORM and have discussed the camp program with the camper's parents(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).**

Name of licensed provider (please print) \_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_

Office Address \_\_\_\_\_

Street City

State Zip Telephone (\_\_\_\_) \_\_\_\_\_

Date \_\_\_\_\_

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Acetaminophen (Tylenol)  
Phenylephrine decongestant (Sudafed PE)  
Antihistamine/allergy medicine  
Diphenhydramine antihistamine/allergy medicine (Benadryl)  
Sore throat spray  
Lice shampoo or cream (Nix or Elimite)  
Calamine lotion  
Laxative for constipation (Ex-Lax)  
Ibuprofen (Advil, Motrin)  
Pseudoephedrine decongestant (Sudafed)  
Guaifenesin cough syrup (Robitussin)  
Dextromethorphan cough syrup (Robitussin DM)  
Generic cough drops  
Antibiotic cream  
Aloe  
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)