

# Horse Heaven Residential Summer Camp

presented by

Monterey Bay Horsemanship & Therapeutic Center

## Health History Examination Form

Dates of Camp Attendance \_\_\_\_\_

The information on the form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history must be filled out by parents/guardians of minors. The last page, Health exam must be completed by approved licensed medical personnel at least every two years. Yearly update required of any medical changes.

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age at camp \_\_\_\_\_

Home address \_\_\_\_\_

\_\_\_\_\_

Custodial parent/guardian \_\_\_\_\_ Home Phone \_\_\_\_\_

Address (if different) \_\_\_\_\_ Cell \_\_\_\_\_

Business address \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Second parent or guardian or emergency contact

\_\_\_\_\_

Address (if different) \_\_\_\_\_ Phone \_\_\_\_\_

If not available in an emergency, notify:

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Insurance Information:

Is the participant covered by family medical/hospital insurance? \_\_\_ yes \_\_\_no

If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

\*\*\*Photocopy of front and back of health insurance card must be attached to this form\*\*\*

Important - The following must be complete for attendance\*

\*Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medication, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied.

Signature of parent/guardian of camper/staff

\_\_\_\_\_

Printed Name \_\_\_\_\_ Date\_\_\_\_\_

\*I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor camper/staff \_\_\_\_\_Date \_\_\_\_\_

\*If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

For office use only:

Name \_\_\_\_\_ Session \_\_\_\_\_Year \_\_\_\_\_

# HEALTH HISTORY

The following information must be filled out by the parent/guardian and/or adult staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known. Describe reaction and management of the reaction.

_____	_____
_____	_____
_____	_____
_____	_____

Food Allergies (list)

_____	_____
_____	_____
_____	_____

Other allergies (list)

_____	_____
_____	_____

## RESTRICTIONS:

The following restrictions apply to this individual:

Dietary

Does not eat red meat \_\_\_\_ Does not eat pork \_\_\_\_ Does not eat eggs \_\_\_\_

Does not eat poultry \_\_\_\_ Does not eat seafood \_\_\_\_ Does not eat dairy products \_\_\_\_

Other (describe) \_\_\_\_

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Explain any restrictions to activity (e.g. what cannot be done, what adaptation or limitation are necessary)

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## MEDICATIONS BEING TAKEN:

Please list ALL medication (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and the frequency of administration.

\_\_\_\_ This person takes NO medications on a routine basis

\_\_\_ This person takes medications as follows:

Medication #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specify time taken \_\_\_\_\_

Reason for taking \_\_\_\_\_

Medication #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specify time taken \_\_\_\_\_

Reason for taking \_\_\_\_\_

Medication #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specify time taken \_\_\_\_\_

Reason for taking \_\_\_\_\_

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer:

\_\_\_\_\_

General Questions (Explain "yes" answers below.)

Has or does the participant:	YES	NO
1. Had any recent injury, illness or infections disease? ___	___	_____
2. Have a chronic or recurring illness/condition? ___	___	_____
3. Ever been hospitalized? .....	___	_____
4. Ever had surgery? .....	___	_____
5. Have frequent headaches? .....	___	_____
6. Ever had head injury? .....	___	_____
7. Ever been knocked unconscious? .....	___	_____
8. Wear glasses, contacts or protective eyewear? ___	___	_____
9. Ever had frequent ear infections? .....	___	_____
10. Ever passed out during or after exercise? ....	___	_____
11. Ever been dizzy during or after exercise? ....	___	_____
12. Ever had seizures? .....	___	_____
13. Ever had chest pain during or after exercise? ___	___	_____
14. Ever had high blood pressure? .....	___	_____
15. Ever been diagnosed with a heart murmur? ___	___	_____
16. Ever had back problems? .....	___	_____
17. Ever had problems with joints (ie. Knees/ankles) ___	___	_____
18. Have an orthodontic appliance? If so, worn when? ___	___	_____
19. Have any skin problems? (rash, itching, acne...) ___	___	_____



HEALTH CARE RECOMMENDATION BY LICENSED MEDICAL PERSONNEL

I examined this individual on \_\_\_\_\_(within 24 months of camp attendance.)

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_ft. \_\_\_\_ in.

In my opinion, the above applicant \_\_\_\_is /\_\_\_\_is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

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Recommendations and Restrictions at Camp

Treatment to be continued at camp

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Medications to be administered at camp (name, dosage, frequency)

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Any medically-prescribed meal plan or dietary restrictions

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Known allergies

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Description of any limitation or restriction on camp activities

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Additional information for health care staff at the camp

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Signature of Licensed Medical Personnel

Printed \_\_\_\_\_ Title \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_ Date \_\_\_\_\_

For Camp Use only  
Screening Record

Date screened \_\_\_\_\_  
Time \_\_\_\_\_ AM / PM  
Meds received \_\_\_\_\_

Updates/additions to health history noted: \_\_\_ Yes \_\_\_ No \_\_\_ None required  
Current health needs identified

Observational notes

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