

Camper's Last Name _____

First Name _____

Office Use Only Tribe _____

HEALTH HISTORY & EXAMINATION FORM

LIGONIER CAMP & CONFERENCE CENTER

- Do not mail ahead. Please bring to camp on incoming day.
- A physical examination is required each year and must be completed by a parent/guardian with up-to-date information.
- Physician's signature is required.

Classic Summer Camp Session # _____ Little Ligs Session # _____ Next Level Session # _____

Camper's Name _____ Birth Date ____/____/____

Camper's Social Security Number _____

Parent/Guardian _____ Home Phone (____) _____

Home Address _____ Cell Phone (____) _____

City _____ State _____ Zip Code _____ Work Phone (____) _____

Employer _____ For whom should I ask at work? _____

Other Contact _____ Contact Phone (____) _____

Please list any known allergies including insect sting, drug, and food allergies, as well as reaction. If none, please mark N/A.

ALLERGIES:

REACTION:

HEALTH HISTORY: *Please include date/description if applicable.*

Chronic illness or medical condition: _____

Surgeries and/or serious injuries: _____

Dietary restrictions: _____

Activities to be limited by physician's advice: _____

Any further information regarding your camper's medical history:

Check the box if your camper has been diagnosed with any of the following:

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Severe Poison Ivy Reaction | Female : |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Measles | <input type="checkbox"/> Wears glasses/ contacts | <input type="checkbox"/> Has menstruation |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Recent Infection | <input type="checkbox"/> Has difficulties with menstruation |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Other | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures | | |

IMPORTANT: *The box below must be completed and signed by parent/guardian to ensure camper's attendance.*

This health history is correct, so far as I know, and the camper described above has permission to engage in all prescribed camp activities, except as noted.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to administer prescription medications as prescribed by physician(s) and over-the-counter medications as directed by the parent(s) and camp protocol, to order X-rays, routine tests, treatment, and necessary related transportation for my 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, for the person named above. This form may be photocopied for trips out of camp.

Signature of Parent/Guardian _____

Date _____

Witness _____

Date _____

Camper's
Last Name _____

First Name _____

Office Use Only
Tribe _____

INSURANCE INFORMATION: *Please complete the information below and attach a photocopy (front & back) of your insurance card.*

Insurance Company _____ Policy # _____
 Name of Insured _____ Group # _____
 Policy Holder's birth date _____ Company Phone Number _____

PRESCRIPTION INFORMATION: (If different than above)

Insurance Company _____ Policy # _____
 Copayment _____

IMMUNIZATION HISTORY: *Required immunizations must be determined by your local primary care physician before coming to camp. Please record the month and year of basic immunizations and most recent booster doses. You may choose to attach a copy of your camper's up-to-date immunization record.*

Vaccines	Month / Year of Basic Immunizations
Diphtheria, Pertussis, Tetanus (DPT) *	
Tetanus, Diphtheria (TD) *	
Tetanus *	
Oral Polio (Sabin) TOPV or Injectable Polio (Salk), IPV	
Measles, Mumps, Rubella (MMR)	

Vaccines	Month / Year of Basic Immunizations
Tuberculin Test (most recent)	
Haemophilus influenza b (HIB)	
Hepatitis B	
Chicken Pox Vaccine	
Other	

*Tetanus must be within 10 years.

TO BE COMPLETED BY LICENSED PHYSICIAN OR NURSE PRACTITIONER:

Date of last physical examination (within 2 years) _____ Height _____ Weight _____

Explanation of any medical conditions/surgeries/injuries: _____

Has this applicant had any reports of loss of consciousness, seizures, or concussion? If yes, explain: _____

Limitations or restrictions to camp activities: _____

Please list any medications/treatments/inhalers to be administered during camp:

Medication/ T(x)	Dosage, Time, Route	Medication/ T(x)	Dosage, Time, Route

Any allergies to food, drugs, plants, insects: _____

Any special considerations with medications: _____

Any diet restrictions or diet specifications: _____

Additional health information: _____

THIS BOX MUST INCLUDE THE SIGNATURE OF A LICENSED PHYSICIAN OR CERTIFIED NURSE PRACTITIONER.

I have examined the above camp applicant within the past two years and in my opinion, this camper's health is stable enough to participate in an active camp program.

Please Print or Stamp Physician's Name: _____

Licensed Physician's Signature: _____ Phone (____) _____

Date of Form Completion: _____ Form Completed by* _____

**Initial if completed by nurse or physician's assistant.*