WEST END HOUSE CAMP HEALTH HISTORY & EXAMINATION FORM **Return to: West End House Camp, Inc.**
Winter: 105 Allston Street, Allston, MA 02134
Summer: 294 Road Between the Ponds, Parsonsfield, ME 04047
E*-mail: steve@westendhousecamp.org, bill@westendhousecamp.org *Tel.: 617-783-2267 Fax: 617-787-4386
This form to be filled in by parent/guardian of campers/staff. RETURN ALL BY 5/1/19!

Name _____Date of Birth _____PLEASE INCLUDE A COPY OF
(last) (first) (middle)

1st Parent /Guardian _____ BOTH SIDES OF YOUR HEALTH INSURANCE CARD!

Home Phone # ( ) _____Cell Phone # ( ) _____E-mail_____

Home Address_____Zip_____

Business Address_____Zip_____

Business Telephone (___)_____Business fax (__)_____ Business email_____

2nd Parent /Guardian _____

Home Phone # ( ) _____Cell Phone # ( ) _____E-mail_____

Business Address_____Zip_____

Business Telephone (___)_____Business fax (__)_____ Business email_____

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This health history is correct as far as I know, and the person herein described has permission to engage in all camp activities, except as noted. In the event I cannot be reached in an emergency, I give permission to the medical personnel or designated camp personnel selected by West End House Camp, Inc. to secure proper treatment (including hospitalization, surgery, sutures, and anesthesia) for my child. I also give permission for routine medical care by West End House Camp, Inc. for my child. It is also understood that the person herein named agrees to abide by any restrictions placed on camp activities. I understand that there is some level of risk at any active camp.
Current Medications Authorization for Administration of Prescription Medication- Please complete a list of each medication, date prescribed, dosage and directions for use and frequency on the other side of this form. Attach additional sheets if necessary.
Over the Counter Medications: West End House Camp Officials are authorized to administer the following over-the-counter medications (such as Tylenol, Ibuprofen, Benadryl, cough drops, antacids) at the recommended doses. ____ Yes _____No
Exceptions: _____
***Signature of parent/guardian* _____Date_____**

MEDICAL INSURANCE: Do you carry medical insurance? _____ If so, please indicate carrier _____

Policy and/or group #_____Name of subscriber_____ Date of Birth_____

Please attach photocopy of both sides of insurance card.

Name of family physician_____ Telephone (___)_____

Name of family dentist_____ Telephone (___)_____

Please list any allergies (food, drugs, plants, insects, etc.)_____

Operations or serious injuries (*dates*) _____
Disability or chronic/recurring illness_____

Does your child receive any additional counseling or behavioral supports at home or at school? _____

Feel free to use extra paper to answer any of the above or below. Equivalent Complete and Recent Reports from the Medical Professional's Office Can Be Submitted Instead of Rewriting Information on the Disease and Immunization Sections.

Health History *(please check as appropriate and give approximate dates)*

Diseases				**Allergies**	
Heart defect/disease	_____	**Mononucleosis**	_____	**Hay fever**	_____
Seizure disorder	_____	**Chicken pox**	_____	**Ivy poisoning, etc.**	_____
Diabetes	_____	**Measles**	_____	**Insect stings**	_____
Bleeding/clotting disorders	_____	**German Measles**	_____	**Penicillin**	_____
Hypertension	_____	**Mumps**	_____	**Other drugs**	_____
Frequent ear infections	_____	**Hepatitis**	_____	**Asthma**	_____

The camper is under the care of a licensed medical professional for the following condition(s) (including epilepsy, diabetes, etc.):

_____

_____

Recommendations and Restrictions While at Camp:

Any treatment to be continued at camp? Any particular issues you want the Health Center to monitor? What else should we know?

_____

_____

Authorization for Administration of Prescription Medication

ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINER WITH PHARMACY LABEL!

Please send the amount of medication (plus a few extra) your camper will need for the time he is at camp!

Check here ___ if your son takes medication on a daily basis.

Check here ___ if your son has medication that he takes on a non-daily, as needed basis.

Check here ___ if your son does not have any medication that he takes regularly.

Name of Medicine: _____ Date Prescribed: _____

Dosage and Directions for Use (and frequency):

_____

Name of Medicine: _____ Date Prescribed: _____

Dosage and Directions for Use (and frequency):

_____

Name of Medicine: _____ Date Prescribed: _____

Dosage and Directions for Use (and frequency):

_____

Any medically prescribed meal plan or dietary restrictions:

_____

Any allergies (food, drugs, plants & insects, etc.):

_____

Additional Health/Dental Information:

_____

IMMUNIZATION HISTORY

Required immunizations must be determined locally. Please record the date (month & year) of basic immunizations and most recent booster doses:

	Dates of Immunizations/Boosters				
DPT/DTaP- Diphtheria-Tetanus-Pertussis					
Td/DT-Tetanus-Diphtheria					
OPV/IPV-Polio					
Hib-Haemophilus influenza type b					
MMR-Measles-Mumps-Rubella					
HB-Hepatitis B					
Varicella-Chicken Pox					
Meningococcal					
Other					
Other					

To the best of my knowledge, the person named above has received the above immunizations.

Camper Height:_____Weight:_____Blood Pressure:_____

Health Examination by Licensed Medical Professional:

I have examined the above camp applicant on _____ and he is approved for participation in all camp activities.

Specify Exceptions:

_____

Please explain any restriction or limitations:

_____

Licensed Medical Professional's Signature:

_____Phone:_____Date:_____

Address_____City/State/Zip:_____

PLEASE ATTACH RECENT PHYSICAL EXAMINATION FORM. THANKS!