Mail this form prior to
3 WEEKS before the first
day of the session attended to:

CAMP RIVERLEA
8302 South Lowell Rd.
Bahama, NC 27503

2010
CAMPER / STAFF - HEALTH-CARE RECOMMENDATIONS BY LICENSED PHYSICIAN

FORM 2

NO OTHER EXAM FORMS ACCEPTED

Parent(s) / Guardian(s) / Staff: Complete the top of this form and present it along with a copy of FORM 1 to the participant's physician for review and completion:

Camper Name: ______________________________ (FIRST / MIDDLE / LAST) Session (check) _____ 1 _____ 2 _____ 3

Birth Date: ______________________________

Parent / Guardian / Staff Phone: (____) ______________, (____) ______________, (____) ______________

PHYSICIAN COMPLETE BELOW

Are there any conditions or other reasons why camper's / staff's participation in the camp program or activities (archery, athletics, swimming, kayaking, canoeing, golf drama, tennis, arts & crafts & music) should be restricted.
☐ YES ☐ NO (Describe): ______________________________

The participant is free of communicable or contagious disease: ☐ YES ☐ NO (Describe): ______________________________

I have examined this participant within the past year.
DATE EXAMINED: ______________________________

Height: ______________ Weight: ______________ Blood Pressure: ______________

Any current or on-going treatment or therapies? ☐ YES ☐ NO (Describe and indicate whether treatment will continued at camp or for duration of camp): ______________________________

Any current or on-going medications: ☐ YES ☐ NO (Please inclued name, dose, frequency & indicate whether they will be given through the duration of the camper's / staff's participation at camp.) ______________________________

Any medically prescribed meal plan or dietary restrictions: ☐ YES ☐ NO (Describe): ______________________________

Allergies: ☐ YES ☐ NO (Describe allergy, reaction and management of allergy): ______________________________

The following non-prescription medications may be available at camp and could be used on an as needed basis to manage illness or injury.
Please cross out those listed below which should not be given to the participant:

Acetaminophen (Tylenol) Ibuprofen (Advil, Motrin) Calamine Lotion

I have 1) completed this form, 2) reviewed CAMPER HEALTH HISTORY FORM 1, and 3) discussed the camp program with the child's parents / guardian(s) / adult staff, and have determined that this child is physically and emotionally fit to participate in camp programs and activities except as noted above. 4) I have answered all the questions above.

Physician's Signature: ______________________________ Print Name: ______________________________

Address: ______________________________ Phone: ______________________________

Completion Date: ______________________________

DON'T FORGET TO ENTER EXAM DATE AND COMPLETION DATE.
THESE DATES MUST BE ENTERED.

Please complete and mail original to camp at least THREE WEEKS before scheduled attendance. This form is mandatory for camp attendance:

2010
CAMPER / STAFF - HEALTH HISTORY
CAMP RIVERLEA
8302 South Lowell Road - Bahama, NC 27503
919-477-8739 or (770) 380-1383

Session (check) _____ 1 _____ 2 _____ 3

FORM 1

Please make a copy of all completed forms for your records.
Parents / Guardian(s) / Staff:
Step 1: Complete FORM 1
Step 2: Make a copy of FORM 1 for review by your child's physician.
Step 3: Complete top of FORM 2
Step 4: Take FORMS 1 and 2 to your child's physician for review and completion.
Step 5: Send signed, completed forms to the above address at least three weeks prior to scheduled attendance.
(Be sure to retain copies for your records.)
Note: Any changes to this form must be provided to camp before or upon participant's arrival at camp.

Participant's Name: ____
FIRST MIDDLE LAST

Birthdate ___/___/___ Age at Camp: _______ Gender: ☐ M ☐ F Social Security # ______________________

Custodial Parent / Guardian (Emergency Contact): ______________________________________

Home Address: ______________________ ______________ ________ ________
STREET CITY STATE ZIP

Telephone Home: (____) ____________ Work: (____) ____________ Cell: (____) ____________

Second Parent / Guardian (Other Emergency Contact): ______________________________________

Telephone Home: (____) ____________ Work: (____) ____________ Cell: (____) ____________

If Parent / Guardian Not Available
In an Emergency - Contact: Name: ______________________ Relationship: _________ Phones: (____) ________(___)_______

Allergies: ☐ No Known Allergies. ☐ Camper Has Allergies.
Please check all applicable box(s).

LIST ALLERGIES — **DESCRIBE REACTION AND MANAGEMENT OF THE REACTION BELOW.**

☐ Medication allergies (list): ____________ ______________________

☐ Food allergies (list): ____________ ______________________

☐ Other allergies (list): ____________ ______________________

Dietary Restrictions: ☐ NO ☐ YES (Describe): ______________________________________

Insurance Information: Insurance Company ______________________ Name of Policy Holder____________________

YOU MUST ATTACH A COPY OF YOUR INSURANCE CARD (FRONT AND BACK)!

Restrictions or Exemptions from Camp Activities:

☐ I have reviewed the program and camp activities in the Parent or Staff Handbook and the participant can fully participate in all the camp activities (archery, athletics, swimming, tennis, golf, nature, drama, arts & crafts, music, canoeing and kayaking) without restrictions or exemptions.

☐ The participant can participate in the camp activities listed above with the following restrictions. (Describe): __________

☐ Participant should be exempt from the camp activities listed above. (Describe): ______________________________

PARENT / GUARDIAN / ADULT STAFF AUTHORIZATION FOR HEALTH CARE

This Health History is correct & complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide, seek and consent to routine healthcare, administration of medications and emergency medical treatment. I hereby give permission to the medical personnel selected by the camp director to provide routine health care & medications, order X-rays, administration of routine tests or treatment. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permisson to the camp to provide or arrange necessary transportation for me and/or 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, order injection, anesthesia or surgery for the person named above. The completed forms may be photocopied for trips out of camp. The camp has permission to obtain a copy of my child's health records from his or her healthcare providers, and these providers may discuss my child's health with the program staff, as necessary.

Signature of Parent:
Guardian/Adult Staff: ______________________________ Date ____________________

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

PLEASE COPY FOR YOUR RECORDS.

PLEASE BE SURE THAT:

1) **You have attached a copy of your insurance card front and back!**
2) **You have signed the signature box above.**
3) **The entire form is complete and all boxes are marked.**

2010

CAMPER / STAFF - HEALTH HISTORY

FORM 1

Participant's Name: ____
FIRST MIDDLE LAST

Immunization History: Please attach a doctor's record, have your doctor complete or give all dates (month & year) for each immunization. Immunizations marked with an asterisk (*) must be current.

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
Diptheria, tetanus, pertussis * (DTaP) or (TdaP)						
Tetanus booster * (dT) or (TdaP)						
Mumps, measles, rubella * (MMR)						
Polio * (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative ☐ Positive

Medication:

(Includes both prescribed medicines and over-the-counter remedies including but not limited to vitamins, natural remedies, inhalers, epi-pens and bee sting kits.)

☐ The participant will take no medication while attending camp.

☐ The participant will take the following medication at home or at camp while attending camp.

PLEASE COMPLETE BELOW FOR ALL MEDICATIONS TAKEN ROUTINELY

Med. #1__________________ Dosage: __________________ Time it is given: ___________________

Date started: ______________ Reason for taking: ____

How given: ________________________________

Med. #2 __________________ Dosage: __________________ Time it is given: ____________________

Date started: ______________ Reason for taking: ____

How given: ________________________________

KEEP THE MEDICATION SENT TO CAMP IN THE ORIGINAL PACKAGING / BOTTLE THAT IDENTIFIES THE PRESCRIBING PHYSICIAN (IF PRESCRIPTION DRUG), THE NAME OF THE MEDICATION DOSAGE AND THE FREQUENCY OF ADMINISTRATION.

The management of some illnesses and/or injuries may call for the use of non-prescription medication. The following non-prescription medicines may be available at camp and could be used on an as-needed basis. Please cross out any that your camper should not be given.

Calamine Lotion

Acetaminophen (Tylenol)

Ibuprofen (Advil Motrin)

2010

CAMP RIVERLEA - CAMPER / STAFF HEALTH HISTORY

FORM 1

Participant's Name: ____
FIRST MIDDLE LAST

General Health Questions (Check No or Yes by each item & record applicable date)

Has / Does the participant:

	DATE:	NO	YES
Diarrhea / Constipation	________	☐	☐
Frequent Ear Infections	________	☐	☐
Heart Defect / Disease	________	☐	☐
Convulsions or Seizures	________	☐	☐
Diabetes	________	☐	☐
Asthma / Wheezing	________	☐	☐
If female, had period & had problems	________	☐	☐
Ever had surgery	________	☐	☐
Wear glasses or contacts	________	☐	☐
Had a significant life event that effects participants life.	________	☐	☐

	DATE:	NO	YES
Recent Injury, Illness or Infectious Desease	________	☐	☐
Chronic or Recurring Illness / Condition	________	☐	☐
Recent or Serious Injuries	________	☐	☐
Headaches	________	☐	☐
Dizzy or Fainting	________	☐	☐
Ever been treated for ADD / ADHD / Learning Disabilities	________	☐	☐
Head Injury	________	☐	☐
Have any skin problems	________	☐	☐
Ever treated for emotional or behavior difficulties or an eating disorder.	________	☐	☐

	DATE:	NO	YES
Hepatitis A, BorC	________	☐	☐
Mononucleosis	________	☐	☐
Chicken Pox	________	☐	☐
Measles	________	☐	☐
German Measles	________	☐	☐
Mumps	________	☐	☐
Ever been in hospital	________	☐	☐
Seen a professional to address mental / emotional health concerns.	________	☐	☐

Explain "YES" answers below:

Any Past Medical Treatment not noted above ☐ NO ☐ YES (Describe):

Dentist / Orthodonist: ______________________________ Family Physician: ______________________________

Phone Number: ______________________________ Phone Number: ______________________________

Are there any current physical, mental or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp or any other information we should know about the participant's health not mentioned on FORM 1 that could prevent their full participation in the camp programs and activities: ☐ YES ☐ NO.

Please describe YES answers below: