Please check whether you are attending:
(June 17-30) 2 Week Junior_____ 2 Week Intermediate _____
(July 2-29) 4 Week Junior_____ 4 Week Int/Sr _____

For Office Use

Health History and Examination Form for Children, Youth and Adults Attending Camps FM 08N

Suggested for resident camp use.

Developed and approved by American Camp Association with the American Academy of Pediatrics

Mail this form to the address below by 5/15/21 (date)

Camp Nakanawa
1084 Camp Nakanawa Road
Crossville TN 38571
Fax: 931/277-5552
campnak@campnakanawa.com

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians of minors or by adults themselves. Update required annually. Health exam (back page) must be completed by approved licensed medical personnel at least every two years.

Year

Name _____ Birth date_____ Age at camp_____
Last First Middle

Home address _____
Street Address City State Zip

Social security number of participant_____ Gender: ☐ Male ☐ Female

Custodial parent/guardian _____ Phone_____

Home address _____
(if different from above) Street Address City State Zip

Business address_____ Phone_____
Street Address City State Zip

Cabin or Group

Second parent or guardian or emergency contact _____

Address _____ Phone_____
Street Address City State Zip

Business address_____ Phone_____
Street Address City State Zip

If not available in an emergency, notify _____

Relationship _____ Phone_____

Address _____
Street Address City State Zip

Insurance Information Date of Birth, Social Security Number and Insurance ID of Policy Holder:_____

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No _____

If so, indicate carrier or plan name_____ Group #_____

***A photocopy of the front and back of your insurance card **must** be attached to this form. Also provide the Social Security Number and birthdate of the insured card holder. This is needed in case of an emergency trip to the hospital or doctor's office.

Important — These boxes must be complete for attendance*

This health history is correct and complete as far as I know. The person herein named 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 health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

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 for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____

Printed Name _____ Date_____

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

Signature of minor or adult camper/staffer_____ Date_____

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

Name

american CAMP association®

Health History

The following information must be filled in by the parent/ guardian, or adult camper or 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.

Medication allergies (list)

_____ _____

_____ _____

_____ _____

_____ _____

Food allergies (list)

_____ _____

_____ _____

_____ _____

Other allergies (list) — include insect stings, hay fever, asthma, animal dander, etc.

_____ _____

_____ _____

_____ _____

MEDICATIONS BEING TAKEN

Please list ALL medications (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 a 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:

Med #1_____ Dosage_____ Specific times taken each day_____

Reason for taking _____

Med #2_____ Dosage_____ Specific times taken each day_____

Reason for taking _____

Med #3_____ Dosage_____ Specific times taken each day_____

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:_____

_____

RESTRICTIONS:

All special dietary needs must be acknowledged by a licensed Physician with a written request to the camp and then approved by the directors. Supplemental foods will be kept in the Commissary. Any possible menu substitutions, questions or concerns must be discussed with the directors prior to May 1st.

Dietary

Our menus can be found on our website: www.campnakanawa.com

☐ 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) _____

_____

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

_____

_____

_____

General Questions {Explain "yes" answers below.)

Has/does the participant:	Yes	No
1. Hod any recent injury, illness or infectious disease?	D	D
2. Hove a chronic or recurring illness/condition?	D	D
3. Ever been hospitalized?	D	D
4. Ever hod surgery?	D	D
5. Have frequent headaches?	D	D
6. Ever hod a head .injury?	D	D
7. Ever been knocked unconscious?	D	D
8. Wear glasses, contacts or protective eye wear?	D	D
9. Ever had frequent ear infections?	D	D
10. Ever passed out during or after exercise?	D	D
11. Ever been dizzy during or after exercise?	D	D
12. Ever had seizures?	D	D
13. Ever had chest pain during or after exercise?	D	D
14. Ever had high blood pressure?	D	D
15. Ever been diagnosed with a heart murmur?	D	D
16. Ever had back problems?	D	D
17. Ever hod problems with joints {e.g., knees, ankles)?	D	D
18. Have an orthodontic appliance being brought to camp?	D	D
19. Have any skin problems {e.g., itching, rash, acne)?	D	D
20. Have diabetes?	D	D
21. Have asthma?	D	D
22. Hod mononucleosis in the past 12 months?	D	D
23. Had problems with diarrhea/constipation?	D	D
24. Have problems with sleepwolking?	D	D
25. If female, have an abnormal menstrual history?	D	D
26. Have o history of bed-wetting?	D	D
27. Ever had an eating disorder?	D	D
28. Ever had emotional difficulties for which professional help was sought?	D	D

Please explain any "yes"answers, noting the number of the questions.

Which of the following hos the participant hod?

0 Measles
O Chicken pox
D Germon measles
O Mumps
D Hepatitis A
0 Hepatitis B
D Hepatitis C

TB Montoux Test
Date of last test _____
.Result: O Positive O Negative

Please give all dates of imm unization for:

Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP						
TD (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Hoemophilus influenza B						
Hepatitis B						
Varicello (chicken pox)						

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Nome of family physician _____ Phone. ___

Address _____

Nomeoffamily dentist/orthodontist _____ Phone _____

Address _____

Health Core Recommendations by Licensed Medical Personnel

I examined this individual on ------ ——·(ACA-occreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

BP ____ Weight _____ Height ——

In my opinion, the above applicant O is O is not able to participate in on active camp prog rom.

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

Recommendations and Restrictions at Comp

Treatment to be continued at camp ——————————

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

Any medically-prescribed meal plan or dietary restrictions ——————————

Known allergies——————————

Description of any limitation or restriction on camp activities ——————————

Additional information for health care staff atthe comp _____

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 healthhistory noted D Yes O No D None required

Currentheohh needsidentffied_____

Observational notes _____

Screened by _____