



933 Friendly Pines Rd • Prescott, AZ 86303
(928) 445-2128 or (602) 255-0550
email: info@friendlypines.com www.friendlypines.com

Please Mail Completed Form By:
 Saturday, May 31 for Session One
 Saturday, June 14 for Session Two
 Saturday, June 28 for Session Three
This form, fully completed and signed on pages 1 & 4, **MUST** be at camp before child's arrival, or she/he will not be permitted to take part in any activities. Parent or guardian completes pp. 1-3 before health exam. **Note: Use this form only, please.** Other forms are not accepted. health exam must be within **12 weeks** of child's coming to camp.

For Office Use

This form was developed by Friendly Pines Camp's consulting physician, based on standards promulgated by the American Camp Association and the American Academy of Pediatrics. The information on this form is not part of the camper acceptance process but

is gathered to give camp health care personnel the background to provide appropriate care. Health history (pgs. 1-3) must be filled out by parents/guardians of minors. Health exam (back page) must be completed by approved licensed medical personnel.

Name _____
Last

Name _____ Birth date _____ Age at Camp _____
Last First (or name used) month/day/year

Home address _____
Street address City State Zip

Grade Next Fall _____ Religious Pref. _____ Gender: Male Female

Custodial parent/guardian _____
Last First Phone (____) _____
Cell (____) _____
Pager (____) _____

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

Business address _____
Street address City State Zip Phone (____) _____

Second parent or guardian or emergency contact _____
Last First

Address _____
Street address City State Zip Phone (____) _____
Cell (____) _____
Pager (____) _____

Business address _____
Street address City State Zip Phone (____) _____

If not available in an emergency, notify:

Name _____
Last First Phone (____) _____
Cell (____) _____
Pager (____) _____

Relationship _____
Work Phone (____) _____

Address _____
Street address City State Zip

Insurance Information

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

If so, indicate carrier or plan name _____

Group#/Name _____ Policy # _____

♦ Photocopy of front and back of health insurance card must be attached to this form.

Important - These boxes 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 medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the Camp to arrange

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 to secure and administer treatment, including hospitalization, for the person named above, and I release Friendly Pines Camp, Inc., its officers, directors, and other personnel from all liability which may result from any of the aforementioned actions. This completed form may be photocopied for trips out of Camp.

Printed Name _____

Signature of parent/guardian **X** _____ Date _____

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

Signature of minor **X** _____ Date _____

First

Cabin

Session

Year

2007 Health History - to be completed by the parent/guardian.

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 will be aware of your needs. This form must be completed annually.

ALLERGIES List all known.

Medication allergies (list)

Describe reaction and management of the reaction.

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

RESTRICTIONS

Dietary restrictions (including food allergies) or medically-prescribed meal plans to be followed at camp:

Describe _____

Explain any restrictions to activity for medical or other reasons (e.g. what cannot/ may not be done, what adaptations or limitations are necessary).

SWIMMING ABILITY ASSESSMENT: I have read the **Swimming Assessment Guidelines** and characterize this child's swimming ability as follows. RELATIONSHIP TO CAMPER _____ INITIAL _____

COMPETENT SWIMMER **NON-SWIMMER/BEGINNER** **NOT SURE OF CHILD'S ABILITY**

MAY CHILD SLEEP ON UPPER BUNK? **YES** **NO**

<p align="center">THIS PERSON TAKES MEDICATIONS ON A ROUTINE BASIS</p> <p><input type="checkbox"/> No. <input type="checkbox"/> Yes. If yes, physical examiner must note on page 4</p>
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PRESCRIPTION MEDICATIONS TO BE ADMINISTERED AT CAMP: On page 4 physical examiner must list **ALL MEDICATIONS** taken routinely and being brought to camp. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician; the patient's name; name of medication; dosage; frequency of administration.

IMPORTANT: THE CAMP'S INFIRMARY IS WELL-STOCKED WITH COMMON OVER-THE-COUNTER MEDS (i.e. Benadryl, cough syrup, Ibuprofen, Tylenol, etc.) DO NOT SEND ANY NON-PRESCRIPTION MEDS TO CAMP, PLEASE.

General Questions (Explain "yes" answers below)

Has/does the participant:		Yes	No		Yes	No	
1.	Had any recent injury, illness or infectious disease?.....	<input type="checkbox"/>	<input type="checkbox"/>	23.	Has ever been treated for asthma-like symptoms?***	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have a chronic or recurring illness/condition?.....	<input type="checkbox"/>	<input type="checkbox"/>	24.	Had mononucleosis?.....	<input type="checkbox"/>	<input type="checkbox"/>
3.	Ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	25.	Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	26.	Ever been a sleepwalker?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	27.	If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	28.	Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Ever been knocked unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	29.	Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Wear glasses, contacts or protective eye wear?.....	<input type="checkbox"/>	<input type="checkbox"/>	30.	Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Ever had eye problems?	<input type="checkbox"/>	<input type="checkbox"/>	31.	Ever had appendix or hernia problems?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Ever had frequent ear infections/problems?.....	<input type="checkbox"/>	<input type="checkbox"/>	32.	Ever had arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Wear corrective hearing devices?	<input type="checkbox"/>	<input type="checkbox"/>	33.	Ever had bleeding or clotting disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
12.	Ever passed out during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	34.	Had any recent colds?.....	<input type="checkbox"/>	<input type="checkbox"/>
13.	Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	35.	Ever had bronchitis?.....	<input type="checkbox"/>	<input type="checkbox"/>
14.	Ever had seizures/epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	36.	History of hyperkinesis/ADD/ADHD?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Ever had chest pain during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	37.	History of hypochondria or malingering?.....	<input type="checkbox"/>	<input type="checkbox"/>
16.	Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	38.	Ever had recurring coughs?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	39.	Ever had frequent indigestion?.....	<input type="checkbox"/>	<input type="checkbox"/>
18.	Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>	40.	Ever had pneumonia or pleurisy?.....	<input type="checkbox"/>	<input type="checkbox"/>
19.	Ever had problems with joints?	<input type="checkbox"/>	<input type="checkbox"/>	41.	Ever had sinus infection?	<input type="checkbox"/>	<input type="checkbox"/>
20.	Have an orthodontic appliance being brought to camp?.....	<input type="checkbox"/>	<input type="checkbox"/>	42.	Ever had tonsillitis and/or frequent sore throat?.....	<input type="checkbox"/>	<input type="checkbox"/>
21.	Have any skin problems (e.g. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>	43.	Ever had strep throat?.....	<input type="checkbox"/>	<input type="checkbox"/>
22.	Have diabetes or hypoglycemia?	<input type="checkbox"/>	<input type="checkbox"/>	44.	Ever had ulcers?	<input type="checkbox"/>	<input type="checkbox"/>
				45.	Other?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers, noting the question number, and describing briefly what treatment is generally used, and/or giving approximate dates of occurrence where appropriate: _____

Any other problem, handicap, injury, disfigurement, or disease history which could affect child, or others, while at camp? _____

****IMPORTANT!** If child has or has been treated for asthma or asthma-like symptoms, please work with your physician in completing the **ASTHMA ACTION PLAN** enclosed. The **ASTHMA ACTION PLAN** must be completed and submitted to Friendly Pines Camp at least two weeks before camper's arrival. This plan could be crucial, so it must be complete and accurate.

		Please give all dates of immunization for:					
Which of the following has the participant had?	Vaccine	Dates	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Measles	DTP		_____	_____	_____	_____	_____
<input type="checkbox"/> Chicken pox	TD (tetanus/diphtheria)		_____	_____	_____	_____	_____
<input type="checkbox"/> German measles	Tetanus		_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Polio		_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	MMR		_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Measles		_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Mumps		_____	_____	_____	_____	_____
	or Rubella		_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B		_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B		_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (chicken pox)		_____	_____	_____	_____	_____
	Pneumonia		_____	_____	_____	_____	_____

Dates must be recorded on this form. Please don't write "Up-to-date" or "refer to last year's form". Copies of immunization records are acceptable.

Note: This form will be returned if all dates are not recorded!

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health, not otherwise noted, and about which the Camp should be aware. _____

Name of family physician _____ Phone (____) _____

Address _____

Name of family dentist/orthodontist _____ Phone (____) _____

Address _____

Note: Please USE THIS FORM ONLY. Other forms are **NOT** accepted. This exam must be **within 12 weeks** of child's coming to camp.
Health Care Recommendations by Licensed Medical Personnel

I examined this individual (Camper Name) _____ ON (Exam Date) _____

Age _____ BP _____ Weight _____ Height _____
Condition of throat _____ Eyes _____ Ears _____ Sinuses _____ Teeth _____ Abdomen _____ Lungs _____
Any heart disorder _____ Skin(Athlete's foot, Impetigo, Ringworm, etc.) _____
Orthopedic _____ Vision L _____ R _____

Any known exposure to (indication of) communicable disease currently? _____

Recommendations and Restrictions at Camp

Please Mail Completed Form By:

- May 31 for Session One
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- June 28 for Session Three

In my opinion, the above applicant is is not able to participate in an active camp program.

Description of any limitation or restriction on camp activities: _____

The applicant is under the care of a physician for the following condition/s: _____

Treatment to be continued at camp: _____

Please Note: For the safety of every person in camp, **ALL CAMPER MEDICATIONS** are kept in the Camp Infirmary, and dispensed by the Camp Medical Staff only as indicated by written instructions of child's doctor. Medications must be labeled with: Camper name, Dr's name and phone number, name of medicine, reason for taking, and frequency of administration. A signed prescription form, including all of the above information, is also acceptable. For obvious reasons, unlabeled and/or non-prescription items are **NOT** dispensed. Re: **INHALERS** - must arrive in pharmacy-labeled box, or have prescription, or duplicate pharmacy-label attached to it. **PLEASE LIST BELOW ANY MEDICATION BEING BROUGHT TO CAMP.**

May Children's Tylenol be given if needed? Yes No State preferred alternate: _____

<input type="checkbox"/> 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 page(s) for more medications. Identify any medications taken during the school year that participant does not/might not take during the summer: _____

For Female: Has this person menstruated? _____ If so, is her menstrual history normal? _____ If not, has she been told about it? _____ Special considerations: _____

KNOWN ALLERGIES: _____

Any medically-prescribed meal plan or dietary restrictions: _____

IMPORTANT: If needed, please attach additional page(s) to provide more information for camp health care staff.

Signature of Licensed Medical Personnel X _____ Printed or Typed Name _____ Title _____ Address _____ Phone(_____) _____ Date _____

Screening Record For camp use only	_____	_____	_____
Date screened	_____	Time	_____ am _____ pm
Meds given to FPC Med Staff	_____		
Initials	_____		
Updates/additions to health history noted	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None required	Weight in _____	Weight out _____
Current health needs identified	_____		
Observational notes	_____		
This person's complete medical record, showing date, complaint, treatment and any other pertinent medical details are all recorded in the Camp Nurse's log for this season.			
Signed X	_____	AZ R.N.# / M.D. # filed in current FPC Standing Orders	Date _____