Tanako Health Form

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. This form is to be filled out by parents/guardians of minors (campers under the age of 18) or by adults themselves.

Name: ____
Last *First* *Middle*

Sessions Attending: ___________________

Session Dates: ___________________

Date of birth: ____________________ Age at Camp: _____

Camper Home Address: ____
Street Address *City* *State* *Zip*

Parent/Guardian ____________________________

Address ____________________________

Home Phone ____________________________

Work Phone ____________________________

Cell/Other ____________________________

Emergency Contact ____________________________

Home Phone ____________________________

Work Phone ____________________________

Cell/Other ____________________________

Relationship to Participant ____________________________

Are there any special circumstances between parent/guardians, emergency contacts, etc. and the participant?
____

Insurance Information

Is the participant covered by family medical/hospital insurance? ___ yes ___ no Camper Social Security Number ______-_____-______

If so, indicate carrier or plan name. ______________________________________ Group # ___________

Carrier Address ____

Name of insured __________________________________ Relationship to participant ____________________

Social Security Number of policyholder or insurance ID number ____

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 physician prescribed medications, and seek emergency medical treatment including the ordering of 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 me/my child from Tanako to the nearest medical facility. 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. Parents/guardians will be notified when advice is needed for on-site treatment or when off-site treatment is required.

Signature of parent/guardian, adult, or staff ____ Date _____________

Printed Name ____

Health Care Recommendations by Licensed Medical Personnel

I examined the above camp participant on ________________________

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

Any restrictions ____

Current treatment at the time of this exam includes: ____
____

Signature of Licensed Medical Personnel ______________________________ Phone # _______________ Date _________

The parent/guardian, adult camper, or staff member must fill in the following information. 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 to camp. Provide complete information so that camp can be aware of your needs.

Allergies *List All Known* — *Describe reaction and management of the reaction.*

Medication Allergies *(list)*

________________________ ____

________________________ ____

Food Allergies/Special Dietary Needs *(list)*

________________________ ____

________________________ ____

Other Allergies *(list) Include insect stings, hay fever, etc.*

________________________ ____

________________________ ____

General Questions *(Explain "yes" answers below.)*

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

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

____

____

Which of the following has the participant had?

- □ Measles
- □ Chicken pox
- □ German measles
- □ Mumps
- □ Hepatitis A
- □ Hepatitis B
- □ Hepatitis C
- □ Whooping Cough

Vaccine	Dates	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		______	______	______	______	______
Tetanus		______	______	______	______	______
Polio		______	______	______	______	______
MMR		______	______	______	______	______
Measles		______	______	______	______	______
Mumps		______	______	______	______	______
Rubella		______	______	______	______	______
Haemophilus influenza B		______	______	______	______	______
Hepatitis B		______	______	______	______	______
Varicella (chicken pox)		______	______	______	______	______

TB Mantoux Test

Date of last test ___________

Result: □ Positive □ Negative

Camper Name:

Camper Name: ___________________________

Please describe any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp.

____

____

____

____

____

Name of family physician ___________________________ Name of family dentist/orthodontist _________________________________

Phone ___________________________ Phone _________________________________

Restrictions

Explain any restrictions to activity (e.g. what cannot be done, any limitations, 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 package/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

You have my permission to administer:

- ☐ Tylenol
- ☐ Antacid
- ☐ Pepto-Bismol

as needed, according to manufacturer's specifications.

☐ This participant takes no medications on a routine basis.

☐ This participant takes (prescription or non-prescription) medication as follows:

Note: Please use the following descriptions for noting medication administration times: Before Breakfast, After Breakfast, Mid-Morning, Before Lunch, After Lunch, Mid-Afternoon, Before Supper, After Supper, Before Bedtime. If other, please detail.

Med #1 ________________ Dosage _________ Directions for Administering Medication ____

____

____

Med #2 ________________ Dosage _________ Directions for Administering Medication ____

____

____

Med #3 ________________ Dosage _________ Directions for Administering Medication ____

____

____

Med #4 ________________ Dosage _________ Directions for Administering Medication ____

____

____

Identify any medications taken during the school year that the participant does/may not take during the summer.

____

____

Office Use Only:
Name: ________________ Cabin ______

Tanako Medication Log

Date	Time	Dispensed	Initials

This section is for treatment notes. It must contain a description of the need for treatment, description of treatment administered, date and time, and the initials of person evaluating and treating. If additional space is needed, add another page and note on this form it has been added.

Visual Observation ☐ Verify Health History ☐ Medications ☐ N/A ☐ Temperature ________
By __________ Date______ Time______
Comment ______________________________