# Jameson Ranch Health Form

**This side to be filled out by parents/guardians of minors or by staff member**

**Please bring this form when you come to camp**

**Please attach a copy of your health insurance card here**
This form should be filled out within 4 weeks of the applicants stay at camp.

NAME____________________ BIRTH DATE________ SEX_____ AGE _____

PARENT / GUARDIAN ____________________

HOME ADDRESS____________________ PHONE________

____________________ Pager #________

BUSINESS ADDRESS____________________ PHONE________

SECOND PARENT OR GUARDIAN OR EMERGENCY CONTACT____________________

HOME ADDRESS ____________________ PHONE________

____________________ Pager #________

BUSINESS ADDRESS____________________ PHONE________

IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY____________________

ADDRESS____________________ PHONE________

HEALTH HISTORY
(Check. Give approximate dates)

- ________ Frequent ear infection
- ________ Heart Defect/Disease
- ________ Convulsions / Epilepsy
- ________ Diabetes
- ________ Bleeding/Clotting Disorders
- ________ Hypertension
- ________ Mononucleosis

Diseases

- ________ Chicken Pox
- ________ Measles
- ________ German Measles
- ________ Mumps

Allergies (Dates not needed)

- ________ Hay Fever
- ________ Poison Oak, etc.
- ________ Insect Stings
- ________ Penicillin
- ________ Other Drugs
- ________ Asthma
- ________ Food or Other (Specify)

________________

________________

Operations or serious injuries (Dates)____________________

____________________

Chronic or recurring illness or medical condition____________________

____________________

Any non prescription drugs?____________________

____________________

Dietary Restrictions ____________________

Name of dentist/orthodontist ____________ Phone________

Name of Family Physician ____________ Phone ________

Family health or hospital insurance carrier ____________________

Policy or Group # ____________________

Carrier Address ____________________

Name of person with insurance ____________________

Concerns or Suggestions on health related information for camp personnel ________

____________________

____________________

For Female:

Has this person menstruated? ________ If not, has she been told about it? ________

If so, is her menstrual history normal? ________ Special consideration ________

**EMERGENCY AUTHORIZATION:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests and treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/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, for the person named above. This completed form may be photocopied for trips out of camp. This health history is correct so far as I know and the person herein has permission to engage in all camp activities except as noted

**Signature of parent or guardian or staff person** ____________________ Date__________

**PHOTO RELEASE** I hereby give consent to Jameson Ranch Camp to use for promotion any photograph of my child taken during camp.

**Signature of Parent** ____________________

I understand and agree to abide with the restrictions placed on my camp activities

**Signature of camper or staff person** ____________________ Date __________

## IMMUNIZATION HISTORY

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

| Vaccines | Year of Immunization or booster | Vaccines | Year of Immunization or booster |
|---|---|---|---|
| DPT: Diphtheria, Pertussis (Whooping cough), Tetanus | | Measles (Hard Measles, Red Measles, Rubella) | |
| TD: Tetanus, Diphtheria | | Mumps | |
| Tetanus | | Rubella (German Measles, 3 Day Measles) | |
| Oral Polio (Sabin)TOPV | | Tuberculin test given (most recent) | |
| Injectable Polio (Salk) | | Haemophilus Influenza B (HIB) | |
| Other | | Hepatitis B | |

## HEALTH EXAMINATION BY LICENSED PHYSICIAN:

I have examined the applicant_________________________________ Date Examined:____________________

In my opinion, the applicant may _____ may not _____ participate in an active camp program.

Height _______________ Weight _________________ Blood Pressure ______________________

The applicant is under the care of a physician for the following condition (s): ______________________________

________________________________________________________________________________

Current treatment (including current medications): ________________________________________________

________________________________________________________________________________

Explanation of any reported loss of consciousness, convulsions or concussion: ___________________________

________________________________________________________________________________

Does the applicant currently have any communicable disease? Yes ___ No ____

If yes, What?______________________________________________________________________

## RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

Any treatment to be continued at camp: ____________________________________________________

________________________________________________________________________________

Any medication to be administered at camp (specify dosage): _________________________________________

________________________________________________________________________________

Any medically prescribed meal plan or dietary restriction: ____________________________________________

________________________________________________________________________________

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

________________________________________________________________________________

Activities to be encouraged or limited: _____________________________________________________

________________________________________________________________________________

Additional health information ___________________________________________________________

________________________________________________________________________________

Licensed Physician's Signature ___________________________________Phone (_____)______________________

Address ______________________________________________________________________________

Date of form completion _______________________________By______________________________________