

# 2010 Larry Hyde Summer Camps

## Health Form Please fill out both sides.

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. Any changes to this form should be provided to camp personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Camp: \_\_\_\_\_ Dates of Attendance: \_\_\_\_\_

Camper's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age at Camp: \_\_\_\_\_

Home Address: \_\_\_\_\_

Social Security of Participant: \_\_\_\_\_ Gender  Male  Female

**Custodial Parent/Guardian:** \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

Business Address: \_\_\_\_\_

**Spouse/Guardian/Emergency Contact:** \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

Business Address: \_\_\_\_\_

**If not available in emergency, notify:** \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

### Insurance Information

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

If so, indicate carrier or plan name: \_\_\_\_\_ Group# \_\_\_\_\_



**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, 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 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 me/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. 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 restriction placed on my participant in camp activities.

Signature of Minor or Adult Camper/Staffer: \_\_\_\_\_

### Allergies List all known and describe reaction and management of the reaction

Medication: \_\_\_\_\_

Food: \_\_\_\_\_

Other (include insect stings, hay fever, asthma, animal dander, etc.): \_\_\_\_\_

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**Restrictions** (The following restrictions apply to this individual.)

Does not eat: \_\_\_\_\_

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		Yes	No
1. Had any recent injury, illness or infectious disease? .....	<input type="checkbox"/>	<input type="checkbox"/>	14. Ever had high blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition? .....	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever been diagnosed with a heart murmur? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized? .....	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever have problems with joints (e.g. knees ,ankles)? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever been knocked unconscious? .....	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever had a head injury? .....	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear? .....	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma? .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections? .....	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleiosis in the past 12 months? .....	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever been dizzy during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation? .....	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever passed out during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>	24. If female, have an abnormal menstrual history? .....	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures? .....	<input type="checkbox"/>	<input type="checkbox"/>	25. Ever had an eating disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had professional help for emotions difficulties? .....	<input type="checkbox"/>	<input type="checkbox"/>

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

\_\_\_\_\_

\_\_\_\_\_

**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: \_\_\_\_\_ Schedule: \_\_\_\_\_

Reason for Taken: \_\_\_\_\_

**Med #2** \_\_\_\_\_ Dosage: \_\_\_\_\_ Schedule: \_\_\_\_\_

Reason for Taken: \_\_\_\_\_

Attach additional pages for more medications.

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

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Name of Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Family Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_



**Please visit our website to download an additional required health form to be completed by your physician.**



**Please return by May 31, 2010 to:**

**Larry Hyde Summer Camps    8801 Cheltenham Avenue    Wyndmoor, PA 19038**