Troop N Camp Cadet
Health Record

Name_____Age_____

Address _____City_____

Zip _____ Telephone # _____

Name of Parents / Guardians_____

Address (if different than Above)_____

Emergency Phone # for Parents _____

Family Physician _____ Telephone # _____

IMPORTANT HEALTH HISTORY (TO BE COMPLETED BY PARENT OR GUARDIAN !!!) ALL QUESTIONS MUST BE ANSWERED AND THE FORM SIGNED BY PARENTS/ GUARDIANS !!

Is child's health generally good ?_____

Are there any known allergies? _____
If yes, Please be specific regarding irritant, symptoms and recommended treatment: _____
_____

DO YOU GIVE CAMP STAFF PERMISSION TO PROVIDE TREATMENT ? YES NO

Is your child subject to (answer Yes or No)

Colds_____ Poison Ivy _____ Fainting _____ Sinus trouble _____

Ear trouble _____ Allergy to insect bites _____ Stomach problems _____ Convulsions _____

Has your child had:

Hay fever _____ Asthma _____ Diabetes _____ Hernia _____

Rheumatic fever _____ Scarlet fever _____ Heart disease _____

Kidney disease _____ Appendicitis _____

Does your child (if a girl) have menstrual periods ? _____

Is your child nervous or upset easily ? _____

Is your child now under medical care for ANY condition ?_____

List_____

_____

Medications

Is your child taking any medication ? Yes ___ or No ____ If yes, Please complete the following:

Medication Name	Dose	Time Taken	Reason for taking

DO YOU GIVE CAMP STAFF PERMISSION TO ADMINISTER MEDICATION AS ORDERED, AND PROVIDE NON-PRESCRIPTION MEDICATIONS FOR MINOR AILMENTS ? Yes _____ No _____

*_____ SIGNATURE OF PARENT / GUARDIAN

DOES YOUR CHILD HAVE ANY ALLERGIES TO MEDICATIONS ? YES _____ NO _____

Please list:

_____
_____
_____

***** **IF YOUR CHILD IS ALLERGIC TO BEE STINGS**, AND DEVELOPS HIVES, SHORTNESS OF BREATH, AND SWELLING OF THE THROAT, YOU **MUST PROVIDE** TO THE HONOR'S CAMP NURSE **A BEE STING KIT** WHICH CAN BE PRESCRIBED BY YOUR FAMILY DOCTOR. ****THERE WILL BE NO EXCEPTIONS, THIS IS REQUIRED FOR YOUR CHILD TO ATTEND CAMP.**

NO CADET WILL BE PERMITTED TO KEEP ANY MEDICATION ON HIS/ HER PERSON, EXCEPT FOR PRESCRIBED INHALERS !!!

ALL MEDICATION MUST BE REGISTERED WITH THE NURSE UPON ARRIVAL AT CAMP !!!

INSURANCE

Is your child covered by health insurance? Yes_____ No _____

Insurance Company Name _____

Address _____

Group #_____

Identification #_____

Policy # _____

Does your child have a Primary Care Provider (PCP)? Yes ____ No ____
Must they be notified prior to emergency care? Yes ____ No ____

If Yes, Name of PCP and Phone Number: _____

Do you have any other type if insurance which will cover your child while at Troop N Camp Cadet?

Yes ____ No ____ (If yes, please provide information)

THE PERMISSION TO TREAT MY CHILD IN THE CASE OF AN EMERGENCY IS CONDITIONED UPON THE UNDERSTANDING THAT IN THE EVENT IF SERIOUS ILLNESS OR THE NEED FOR HOSPITALIZATION AND/OR SURGERY, THE STAFF WILL USE ALL REASONABLE EFFORTS TO CONTACT ME. FAILURE IN SUCH EFFORTS; HOWEVER, SHOULD NOT PREVENT A PHYSICIAN FROM PROVIDING SUCH EMERGENCY TREATMENT AS MAY BE NECESSARY FOR THE BEST INTEREST OF MY CHILD.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

Have your Physician Complete this page:

Have there been any past operations, injuries, or illnesses? _____ Yes _____ No
If yes, please describe type, approximate date and if still under care for this problem, or anticipating further treatment:

_____
_____
_____

All youth are expected to participate in daily exercises and activities which include but are not limited to running, jumping, and swimming…IS THERE ANY KNOWN PHYSICAL IMPAIRMENT THAT MIGHT HANDICAP THIS CHILD FROM FULLY PARTICIPATING IN A STRENUOUS PROGRAM SUCH AS CAMP CADET ? _____**Yes** _____ **NO**
If yes, Please describe:

_____
_____

* _____ * _____
Signature of treating physician, ONLY if still under care, or needing further treatments. Signature of Parent / Guardian

Date of last tetanus shot _____ Note - This must be within the last ten years.

All youth must be up-to date with Pennsylvania's Recommended School Immunizations before attending this program. The following lists the vaccinations needed:

Hepatitis B (Hep B) - A series of doses of hepatitis B vaccine if you have not already received them.
Measles, Mumps, Rubella (MMR) - Check with your healthcare provider to make sure you've had two doses of MMR.
Tetanus, diphtheria, pertussis (whooping cough) - A booster dose of Tdap at age 11-12 years. If older and already had a Td booster, you should get a Tdap shot to get the extra protection against pertussis.
Polio - If you haven't completed your series of polio vaccine doses and you are not yet 18, you should complete them now.
Varicella (Var) (chickenpox shot) - If you have not been previously vaccinated and have not had chickenpox, you should get vaccinated against this disease. The vaccine is given as a 2-dose series. Any teenager who was vaccinated as a child with only 1 dose should get a second dose now.
Meningococcal disease - This vaccine is recommended for all teens ages 11 through 18 years, college freshmen who will be or are living in dormitories, and those with certain special medical conditions. *** If recommended by your healthcare provider.

I have reviewed the Immunization list and verify that this youth has had ALL required immunizations for participation in this camp. *_____ Physicians Initials

I HAVE EXAMINED THIS CHILD AND HE/SHE IS ABLE TO ATTEND AND PARTICIPATE AT TROOP N CAMP CADET:

*_____ **Physician Signature**