2008 Ebner Camps Inc. Health Form
For Youth & Adults Attending Camp

*Session attending: ______________________________

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 health personnel upon participant's arrival in camp. Incomplete forms will be returned to you!

First Name:___________________________ Middle:____________________ Last:____________________________

Home Address:____

Birth Date:________________ Age at camp:________ Gender: ☐ Male ☐ Female

Custodial Parents/Guardians: #1 _____________________ #2 _____________________ Phone: ( )____________

Parent 1: Work Phone: ( ) ________________________ Cell Phone: ( ) _____________________

Parent 2: Work Phone: ( ) ________________________ Cell Phone: ( ) _____________________

If not available in an emergency, notify:____

Relationship to Participant:________________________________ Phone: ( ) _____________________________

Address:____

Street City State Zip

A PHOTOCOPY OF THE FRONT AND BACK OF HEALTH INSURANCE CARD(S) MUST BE ATTACHED TO THIS FORM

Administration of Bug Repellant

_____ I give the employees of Ebner Camps Inc. permission to apply bug repellant containing DEET to my child in accordance with the instructions of the attending physician and manufacturers recommendations to prevent against mosquitoes and ticks.

_____ I do not wish for my child to receive bug repellant.

Administration of Sunscreen

_____ I give the employees of Ebner Camps Inc. permission to apply sunscreen to my child.

_____ I do not give the employees of Ebner Camps Inc. permission to apply sunscreen to my child.

Dietary Restrictions: (The following restrictions apply to this individual):

Does not eat: ☐ Red Meat ☐ Pork ☐ Dairy Products ☐ Poultry ☐ Seafood ☐ Eggs Other:__________________

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

Allergies - Please list all known

Describe reaction and management of reaction

Food allergies:

__________________________________ ____

Medication/Other allergies:

__________________________________ ____

General Questions: (Explain YES answers below)

Has/does the participant:

1. Had any recent injury, illness, or infectious disease? Y / N
2. Have a chronic or recurring illness/condition ? Y / N
3. Ever been hospitalized? Y / N
4. Ever had surgery? Y / N
5. Wear glasses, contacts, or protective eyewear? Y / N
6. Ever had frequent ear infections? Y / N
7. Ever had seizures? Y / N
8. Have diabetes? Y / N
9. Have asthma? Y / N
10. Have a history of bed-wetting? Y / N
11. Have problems with sleepwalking? Y / N
12. Have any skin problems (itching, rash, acne)? Y / N
13. Have an orthodontic appliance coming to camp? Y / N
14. Had mononucleosis in the past 12 months? Y / N
15. If female, have abnormal menstrual history? Y / N
16. Ever had an eating disorder? Y / N
17. Ever had emotional difficulties for which Professional help was sought? Y / N
18. Any recent exposure to contagious diseases? Y / N

Please explain any **YES** answers, noting the question number: ____

____

PLEASE TURN OVER & COMPLETE REVERSE SIDE

Camper Name: ____________________________________ Session(s) attending: ______________________

Prescription and Daily Non-Prescription Medications:

☐ This person takes medications routinely ☐ This person does NOT take medications routinely

In accordance with state law, each medication, either prescription or over the counter, that is taken routinely, must have a completed medication administration form signed by the physician.

Non-Prescription Medications:

The following medications are stocked in our infirmary and are available to be administered to your child in accordance with the standing orders of the camp physician. For more information on these medications please see the enclosed pamphlet.

Please circle whether or not the camp health personnel may administer these medications to your child if necessary:

Robitussin (Guaifenesin Syrup)	Y / N	Ibuprofen	Y / N	PeptoBismol (or generic)	Y / N
Benadryl (Diphenhydramine)	Y / N	Chloroseptic spray	Y / N	Midol	Y / N
Tylenol (Acetaminophen)	Y / N	Milk of Magnesia	Y / N	Cepacol lozenges	Y / N
Bacitracin(Triple antibiotic) ointment	Y / N	Rolaids/Tums	Y / N	Mylanta	Y / N
Sudafed (pseudoephedrine)	Y / N	Hydrocortisone	Y / N	Betadine/Povidine	Y / N
Dimetapp (pseudoepherdine HCl)	Y / N	Visine eye drops	Y / N	Ben gay ointment	Y / N
Immodium (Loperamide)	Y / N	Tussin DF	Y / N	Tinactin (Tolnaftate)	Y / N

** IMPORTANT—THIS BOX MUST BE COMPLETE FOR ATTENDANCE **

Parent/Guardian Authorization: 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 staff:____

Printed name:_____________________________________ Date:__________________________

Which of the following has the participant had?

- Measles ☐
- Chicken Pox ☐
- German Measles ☐
- Mumps ☐
- Hepatitis A ☐
- Hepatitis B ☐
- Hepatitis C ☐
- Other:_______________
- Other:_______________

Please give last booster date of the following immunizations:

DPT series _________ TD (Tetanus/Diphtheria)________ Polio OPV (Sabin)_________

MMR___________ OR Mumps________ Measles________ Rubella___________

Influenza B ___________ Hepatitis B _________ Varicella __________ (chicken pox)

TB Mantoux test ___________ result: ☐ positive ☐ negative

Height ___________ Weight ___________ B/P ____________ Gross dental exam ___________

PLEASE use a separate sheet to provide any additional information about the participant's behavior & physical, emotional, or mental health about which the camp should be aware.

Name of participant's physician:________________________________ Phone: ( ) ______________________

Address:____

NOTE TO PHYSICIAN/HEALTH CARE PROVIDER: It is understood that by signing this form you, the Physician/Health Care Provider, agree with parent/guardian decisions regarding administration of non-prescription drugs/treatments (see above).

Signature of Physician:	Printed Name:	Date Signed:	Date of last physical:
______________________	______________________	______________	______________

Return this form to: Ebner Camps, Inc., 1 Torrington Office Plaza Suite 308 Torrington, CT 06790