

RETURN TO:

The Barton Center for Diabetes Education, Inc.

Attn. Camp Director, P.O Box 356, 30 Ennis Road, North Oxford,

MA 01537 Tel: (508) 987-2056 FAX: (508) 987-2002

www.bartoncenter.org

HEALTH EXAMINATION FORM FOR STAFF/CAMPERS

PARENTS/GUARDIANS/STAFF: YOUR CHILD/YOU CANNOT PARTICIPATE IN THE CAMP PROGRAM WITHOUT A COMPLETED HEALTH FORM (INCLUDING SIGNED MEDICAL RELEASES)

CAMPER/STAFF NAME _____ BIRTH DATE _____ AGE _____
First MI Last

PARENTS'/GUARDIANS' NAMES _____

CAMPER/STAFF HOME ADDRESS _____
Street City State Zip

PHONE NUMBER(S) WHERE PARENTS/GUARDIANS CAN BE REACHED DURING CAMP SESSION
(home) _____ (work) _____ (cell) _____ (pager) _____

In an emergency, contact _____ at _____

HEALTH HISTORY (Check all that apply and give approximate dates)

- | | | |
|--|---|---|
| <input type="checkbox"/> Frequent Ear Infections _____ | <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Allergies: Hay Fever _____ |
| <input type="checkbox"/> Heart Defect/Disease _____ | <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Ivy Poisoning, etc. _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> German Measles _____ | <input type="checkbox"/> Penicillin _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> Other Drugs _____ |
| <input type="checkbox"/> Bleeding/Clotting Disorders _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Other _____ |

Other illness or details of above _____

Surgery or serious injuries (list with dates) _____

Chronic or recurring illness _____

Type of meal plan followed: none ADA (calories) _____ Carbohydrate Counting _____

Other _____

All medications other than insulin (names/doses/times) _____

****CAMPERS/STAFF MUST BRING ALL MEDICATIONS (other than insulin) TO CAMP WITH THEM****

(For girls) Has she menstruated? ____ If no, has she been told about it? ____ If yes, is her menstrual history normal? ____

Additional Comments _____

****Please notify camp if the camper/staff member is exposed to any communicable disease during the three weeks prior to camp****

IMPORTANT – MUST BE COMPLETED FOR ATTENDANCE

Parent/Guardian/Staff authorization. This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me and/or the examining health care provider.

I authorize The Barton Center for Diabetes Education, Inc. (d.b.a. Clara Barton Camp) to release or receive all medical records, for the above named camper/staff member, including but not limited to those records pertaining to substance abuse and emotional or mental health.

I hereby give permission to the health care provider selected by the Camp Administrator to order X-rays, routine tests, and treatment for the health of my child/me, and in the event I cannot be reached in an emergency, I hereby give permission to the health care provider selected by the Camp Administrator to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child/myself as named above.

Signature _____ Witness _____ Date _____

OVER

