

New Mexico Forestry Camp
2010 Camper Health

New Mexico Forestry Camp
c/o Jean Szymanski, R3-PAO
333 Broadway SE
Albuquerque, NM 87102

Dear Parent/Guardian,

To help us prepare and to ensure the well-being of all attending camp, this health form must be completed.
If you have any questions, please contact the camp registrar at (505) 842-3325 or (575) 289-3950.

Please Print Clearly

SECTION A Camper Health Care Information

Camper Name _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Age _____ Grade entering in fall of 2009 _____

Custodial Care Information

My camper is under the custodial care of (check one):

Both parents

Mother only

Father only

Other

Name

Relationship

Contact Information

Parent/Guardian Name Home Phone Work Phone Cell Phone/Other

Parent/Guardian Name Home Phone Work Phone Cell Phone/Other

Emergency Contact (person to contact if parent/guardian cannot be reached in emergency)

Name _____ Relationship _____

Phone number(s) _____
Home Phone Work Phone Cell Phone/Other

Address _____ City _____ State _____ Zip _____

Insurance Information

Is the camper covered by family medical/hospital insurance?

Yes No

If yes, carrier or plan name _____ Group # _____

Carrier Address _____

Name of Insured _____

Policy Holder's Insurance policy ID number _____

Health History

This information must be completed by the parent/guardian to provide camp healthcare personnel with the background to provide appropriate care. Any changes should be shared with camp personnel upon arrival at camp.

Allergies

List all known (medication, food, insect stings, hay fever, etc.)

Describe reaction and management of the reaction

Medications

Please list all medications (including over-the-counter or non-prescription medications) the person takes routinely. Bring enough medication, in the original packaging/bottle with its prescription or over-the-counter label, to last the entire camp session. By completing the following information, you are giving permission for camp staff to administer the following:

This camper Takes NO medications on a routine basis. Takes prescription/over-the-counter medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

This camper takes the following medications during the school year which she does not/may not take during the summer:

The following mental, emotional, and psychological health information will help our professional camp staff prepare and provide the best care for New Mexico Forestry campers.

- | | | |
|---|------------------------------|-----------------------------|
| 1. This camper has an emotional health concern that will impact camp participation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. This camper has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. This camper has a significant life event that continues to affect the camper's life/health | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. This camper uses an individualized learning plan at school (IEP) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If "yes" was the answer to any of the four statements above, attach a statement from the camper's professional (e.g., physician, psychiatrist, therapist) that addresses the following with regard to the camper's participation at camp:

- Describes the concern and the camper's management plan (including medications) while at camp;
- Describes the behaviors that will indicate to our staff that your camper needs professional referral; and
- Provides a recommendation from this professional supporting your child's participation in our camp program.

General Health Information

Has/does the camper:		Yes	No			Yes	No
1. Had recent injury, illness/infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>		16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>		17. Ever had joint problems (knees, ankles, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>		18. Brought an orthodontic appliance to camp?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>		19. Have any skin problems (itching, rash, acne, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>		20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>		21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>		22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Wear glasses, contacts, or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>		23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>		24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		25. Have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		26. Have a history of bedwetting?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>		27. Have an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>		29. Had lice, ringworm, or scabies in the past 2 months?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>		30. Has behavioral challenges (ADD, other)	<input type="checkbox"/>	<input type="checkbox"/>	

If yes to any question, please explain (noting question number being referenced):

Camper has had the following:

- Measles Mumps Chicken pox Hepatitis German measles

Camper has had these other diseases/major illnesses:

Please give date of last immunization for:

_____ DPT _____ TD (tetanus/diphtheria) _____ Tetanus _____ Varicella (chicken pox)
 _____ Polio _____ MMR or (Measles Mumps Rubella) _____ Hepatitis B _____ Haemophilus influenza B
 _____ Date of last TB Mantoux test; result: Positive Negative

Date of last physical exam (include year) _____

Camper's Physician _____

Phone _____

Camper's Dentist/Orthodontist _____

Phone _____

Special Dietary/Activities Restrictions

The following restrictions apply to this individual.

Dietary Does not eat red meat Does not eat pork Does not eat eggs
 Does not eat poultry Does not eat seafood Does not eat dairy products
 Other (describe) _____

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

Signatures Important – Must be completed for attendance

This health history is correct and complete as far as I know. The person herein described has permission to engage in all prescribed camp activities except as noted.

I hereby give permission to the camp healthcare staff to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp healthcare staff to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp healthcare staff be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as “personal representatives” for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR 164.510(b) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the event representatives related to the person’s ability to participate in camp activities; (ii) in the case of minors, to provide relevant information to the event representatives to keep me informed of my child’s health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp representatives 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/Guardian _____

Printed Name _____ **Date** _____

** If for religious reason you cannot sign this, contact the council for a legal waiver which must be signed for attendance.*

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

Signature of Minor _____ **Date** _____

Return this form with the 1) 2010 Forestry Camp Permission, 2) Over the Counter Medication Authorization, 3) Camper Contract and 4) 2010 Camper Health, section B.