

New Mexico Forestry Camp 2010 Health Information for Counselors

Send completed form to:

New Mexico Forestry Camp
c/o Marsha S. Hagerdon
Mt. Taylor Ranger District
1800 Lobo Canyon Road
Grants, NM 87020

Dear Counselor:

To ensure the well-being of all attending, this form must be completed and **returned by Monday May 3, 2010**. Complete Section A. Section B must be completed by a licensed medical specialist. Please keep Section C attached.

SECTION A **Attendee Health Care Information**

Attendee Name _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Age _____

Contact Information (please give complete information for all three)

Spouse or Significant Other _____
Name Home Phone Work Phone Cell Phone/Other

Relative _____
Name Home Phone Work Phone Cell Phone/Other

Friend _____
Name Home Phone Work Phone Cell Phone/Other

Emergency Contact (person to contact if spouse/significant other cannot be reached in emergency)

Name _____ Relationship _____

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

Address _____ City _____ State _____ Zip _____

Insurance Information

Are you 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 counselor to provide event healthcare personnel with the background to provide appropriate care.

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) you take routinely. Bring enough medication, in the original packaging/bottle with its prescription or over-the-counter label, to last the entire event. By completing the following information, you are giving permission for event healthcare staff to administer the following:

This counselor 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 person may take, under the event healthcare staff, the following medications or generic equivalents:

Acetaminophen (Tylenol) Liquid Tablet

Children's (80mg), according to weight: _____ lbs

Junior (160mg), according to weight: _____ lbs

Regular (325mg), # of tablets: _____

Extra-strength (500mg), # of tablets: _____

Ibuprofen Tablet 100 mg 200 mg

of tablets _____

Calamine lotion (topical for poison ivy/bug bites)

Cepacol lozenges

Sudafed liquid or tablets (as directed on label)

Kaopectate – Children's (as directed on label)

Robitussin DM (as directed on label)

Benadryl (for swollen bee stings)

Triple Antibiotic Cream (Neosporin)

General Health Information

Has/does the attendee:	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):

Attendee has had the following:

Measles Mumps Chicken pox Hepatitis German measles

Attendee 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) _____

Attendee's Physician _____

Phone _____

Attendee's Dentist/Orthodontist _____

Phone _____

(General Health Information continued)

The following mental, emotional, and psychological health information will help our event healthcare staff prepare and provide the best care for attendees.

- 1. This attendee has an emotional health concern that will impact camp participation Yes No
- 2. This attendee has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder Yes No
- 3. This attendee has a significant life event that continues to affect the attendee's life/health Yes No

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

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

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.

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 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 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 my protected health information, as necessary: to provide relevant information to the event representatives related to my ability to participate in camp activities.

I hereby give permission to the physician selected by the camp representatives to secure and administer treatment, including hospitalization, for me. This completed form may be photocopied for trips out of camp.

Signature _____

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 any restrictions placed on my camp activities.

Signature of Adult Counselor _____ Date _____

New Mexico Forestry Camp 2010 Counselor Health

Section B Health Care Recommendation/Physical Examination

I have examined the above person participant on this date: _____

BP _____ Weight _____ Height _____

In my opinion, the above applicant IS NOT IS ABLE to participate in an active camp program.

The applicant is under the care of a physician for the following conditions: _____

Current treatment at the time of this report includes: _____

Recommendations and Restrictions at Camp

Treatment to be continued at camp _____

Medications to be administered at camp (name, dosage, frequency) _____

Known allergies _____

Description of any limitation or restriction on camp activities _____

Additional information for health care staff at the camp _____

Signature of Licensed Medical Personnel

Signature _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

New Mexico Forestry Camp

2010 Counselor Health

Section C Counselor Attendance Health Screening

For Forestry Camp use only

Arrival Screening: conducted according to camp protocol with these findings:

Date & Time _____ By Who _____

- a. Any updates to the health history form? No Yes as noted below
 - b. Any signs /symptoms of illness or injury? No Yes as noted below
 - c. Any medications given to health center staff? No Yes as noted below
 - d. Any special needs of this person while at camp? No Yes as noted below
-
-
-
-
-
-
-
-

Exit Note

Date & Time _____ By Who _____

Check one:

Left camp this day with no reported injury or illness signs/symptoms.

Left camp this day with the following problem/concern: _____

Person who was told about this problem or concern: _____

Health record closed by:

Signature _____ Date: _____