



# 2008 Kamp Kiwanis® Health History

## Kamp Kiwanis

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kamp@kiwanis-ny.org www.kiwanis-ny.org/kamp

Health history (first three pages) must be filled out by parents/guardians of minors or by adults themselves. Update required annually. Health exam (back page) must be completed by approved licensed medical personnel and update is required annually also.

Name \_\_\_\_\_ Birth date \_\_\_\_\_

Home address \_\_\_\_\_  
*Street Address City State Zip*

Social security number of participant \_\_\_\_\_ Gender:(circle one) Male Female

<b>Parent/Guardian #1</b>	<b>Emergency Contact #1 (Must <u>NOT</u> be a Parent or Guardian)</b>
Name _____	Name _____
Home phone _____	Relationship _____
Work phone _____	Home phone _____
Cell phone _____	Work phone _____
	Cell phone _____
<b>Parent/Guardian #2</b>	<b>Emergency Contact #2 (Must <u>NOT</u> be a Parent or Guardian)</b>
Name _____	Name _____
Home phone _____	Relationship _____
Work phone _____	Home phone _____
Cell phone _____	Work phone _____
	Cell phone _____

## Insurance Information

Is the participant covered by family medical/hospital insurance, Medicaid or Medicare? (circle one) Yes No

If so, indicate carrier or plan name \_\_\_\_\_ Group# \_\_\_\_\_

Carrier Address \_\_\_\_\_

Name of Insured \_\_\_\_\_ Insurance ID # or SS # of policy holder \_\_\_\_\_

Doctors Name \_\_\_\_\_ Doctors Phone \_\_\_\_\_

### Photocopy of front and back of health insurance card must be attached to this form.

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

I hereby give permission to the Kamp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my kamper, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the Kamp 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 Kamp 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 Kamp 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 Kamp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the Kamp representatives related to the person's ability to participate in Kamp activities; and (ii) in the case of minors, to provide relevant information to the Kamp representatives to keep me informed of my kamper's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Kamp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of Kamp.

 Signature of parent or guardian or adult Kamper/staffer \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide by any restrictions placed on my participation in Kamp activities.

Signature of minor kamper/minor volunteer or adult Kamper \_\_\_\_\_ Date \_\_\_\_\_

# Kamp Kiwanis Health History Continued, Page 2

Health history (first three pages) must be filled out by parents/guardians of minors or by adults themselves. Update required annually. Health exam (back page) must be completed by approved licensed medical personnel and update is required annually also.

**Kamper Name** \_\_\_\_\_

**Medications being taken** Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at Kamp. Keep it in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

**Medications not sent in their original containers, by NY State Law cannot be dispensed**

This person takes medication on a routine basis? (circle one)      Yes      No

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific time taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific time taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific time taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #4 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific time taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

**Please identify any medications taken during the school year that the participant may not take during the summer?**

\_\_\_\_\_

\_\_\_\_\_

**Allergies** List all known. Circle one and describe reaction and management of the reaction.

Medication allergies      Yes      No      Reaction \_\_\_\_\_

Food allergies              Yes      No      Reaction \_\_\_\_\_

Other allergies              Yes      No      Reaction \_\_\_\_\_

**Restrictions** (The following restrictions apply to this individual)

**Does not eat:** Red meat \_\_\_\_\_ Pork \_\_\_\_\_ Dairy Products \_\_\_\_\_ Poultry \_\_\_\_\_ Seafood \_\_\_\_\_ Eggs \_\_\_\_\_

Other (describe) \_\_\_\_\_

**Activity Restrictions:** Swimming \_\_\_\_\_ Hiking \_\_\_\_\_ Canoeing \_\_\_\_\_ Sports \_\_\_\_\_ Strenuous Activities \_\_\_\_\_

Specific Activities to be restricted: \_\_\_\_\_

Suggestions from Parents/Guardians: \_\_\_\_\_

**General Questions** (Explain "yes" answers below)

Has/does the participant:

- |  |     |    |   |     |    |
|--|-----|----|---|-----|----|
| 1. Had recent injury, illness or infectious disease? | Yes | No | 20. Ever had problems with joints? Eg. Knees, ankles                    | Yes | No |
| 2. Have a chronic or recurring illness or condition? | Yes | No | 21. Have an orthodontic appliance being brought to Kamp?                | Yes | No |
| 3. Ever been hospitalized?                           | Yes | No | 22. Have any skin problems? Eg. Itching, rash, acne                     | Yes | No |
| 4. Ever had surgery?                                 | Yes | No | 23. Have Diabetes?  | Yes | No |
| 5. Have frequent headaches?                          | Yes | No | 24. Have Asthma?  | Yes | No |
| 6. Ever had a head injury?                           | Yes | No | 25. Had Mononucleosis in the past 12 months?                            | Yes | No |
| 7. Ever been knocked unconscious?                    | Yes | No | 26. Had problems with diarrhea/constipation?                            | Yes | No |
| 8. Wears glasses, contacts or protective eye wear?   | Yes | No | 27. Have problems with sleepwalking?                                    | Yes | No |
| 9. Ever had frequent ear infections?                 | Yes | No | 28. If female, has begun menstruation?                                  | Yes | No |
| 10. Ever been dizzy during or after exercise?        | Yes | No | 29. If female, had had an abnormal menstruation history?                | Yes | No |
| 11. Ever passed out during or after exercise?        | Yes | No | 30. Ever had an eating disorder?  | Yes | No |
| 12. Ever had seizures?                               | Yes | No | 31. Ever had emotional difficulties where professional help was sought? | Yes | No |
| 13. Ever had chest pain during or after exercise?    | Yes | No | 32. Ever had measles?   | Yes | No |
| 14. Ever had high blood pressure?                    | Yes | No | 33. Ever had mumps?   | Yes | No |
| 15. Ever had back problems?                          | Yes | No | 34. Had lice in the last 6 months?                                      | Yes | No |
| 16. Ever been diagnosed with a heart murmur?         | Yes | No | 35. Suffer from hay fever?  | Yes | No |
| 17. Allergic to insect stings?                       | Yes | No | 36. Ever had chicken pox?   | Yes | No |
| 18. Allergy to ivy poisoning?                        | Yes | No | 37. Allergic to Penicillin?   | Yes | No |

Please explain yes to answers: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Kamp Kiwanis Health History Continued, Page 3

Kamper Name: \_\_\_\_\_

**Does this kamper have any special needs to include ADD or ADHD? (circle one) Yes No**  
**If the answer is yes, continue with the questions below, if no, proceed to page 4, Kamper Health Exam.**

**Primary Diagnosis** \_\_\_\_\_ **Secondary Diagnosis** \_\_\_\_\_  
Does the applicant have: \_\_\_ Mobility Impairment \_\_\_ Hearing Impairment \_\_\_ Mental Retardation \_\_\_ ADD  
\_\_\_ ADHD \_\_\_ Epilepsy \_\_\_ Diabetes \_\_\_ Autism \_\_\_ Cerebral Palsy \_\_\_ Seizure Disorder \_\_\_ Visual impairment  
\_\_\_ Other (please list) \_\_\_\_\_

**Adaptive Equipment** (please check all devices used by the kamper)  
\_\_\_ Glasses \_\_\_ Wheelchair \_\_\_ Hearing Aid \_\_\_ Shoes \_\_\_ Crutches \_\_\_ Walker \_\_\_ Braces (type) \_\_\_\_\_  
List any others and special instructions/information \_\_\_\_\_

**Reports** Is there a behavioral report? (circle one) Yes No Is there a psychological report? (circle one) Yes No  
If the answer to either of the above questions is Yes, please forward. All information will maintain confidentiality.

**Kamper Specific Questions** For the following information, please check any items that pertain to this kamper.

Severity of Mental Retardation: \_\_\_ Mild \_\_\_ Moderate \_\_\_ Severe \_\_\_ Profound Does the Kamper have Epilepsy? (circle one) Yes No

**SEIZURE:** Has the Kamper ever had a seizure? Yes No Please explain: \_\_\_\_\_

Type of seizures Kamper has at this time: \_\_\_ None \_\_\_ Petit Mal \_\_\_ Grand Mal How Often? \_\_\_\_\_

Nocturnal seizures? Yes No How often? \_\_\_\_\_ Treatment during and after seizure? \_\_\_\_\_

**AMBULATION:** \_\_\_ Walks Freely \_\_\_ Walks with Difficulty \_\_\_ Uses Aids \_\_\_ Uses a Wheelchair How Often? \_\_\_\_\_  
If ambulatory, can kamper walk up/down stairs unaided? Yes No What type of wheelchair does the kamper use: Manual Electric  
Please explain battery charging requirements: \_\_\_\_\_

**VISION:** \_\_\_ 20/20 \_\_\_ Partial \_\_\_ Legally Blind \_\_\_ Uses Glasses \_\_\_ Uses Contacts

**HEARING:** \_\_\_ No Problem \_\_\_ Deaf \_\_\_ Hearing Aid **SPEECH:** \_\_\_ Hard To Understand \_\_\_ Non Verbal

**COMPREHENSION:** \_\_\_ No Problem \_\_\_ Understands only simple directions \_\_\_ Does not understand

Please Explain: \_\_\_\_\_

**SLEEPING:** \_\_\_ No Problem \_\_\_ Occasional Problem \_\_\_ Often awake at night \_\_\_ Wanders \_\_\_ Incontinence

Please Explain: \_\_\_\_\_

On average, how many hours does your kamper sleep? \_\_\_\_\_ Can sleep in upper bunk? Yes No (adult kampers will use bottom bunks)  
Does Kamper need to be checked during the night? Yes No (Staff members sleep in each cabin) Reason: \_\_\_\_\_

**DRESSING:** \_\_\_ Independent \_\_\_ Some Assistance \_\_\_ Complete Assistance

**SHOWERING:** \_\_\_ Independent \_\_\_ Some Assistance \_\_\_ Complete Assistance

**USING THE TOILET:** \_\_\_ Independent \_\_\_ Some Assistance \_\_\_ Complete Assistance

Please explain: \_\_\_\_\_

(Enough Attends/Depends/Diapers must be sent with the kamper. You will be billed for the cost of the supplies, if enough are not sent.)

**EATING:** \_\_\_ Independent \_\_\_ Some Assistance \_\_\_ Complete Assistance

**MY KAMPER EATS FOOD THAT IS:** \_\_\_ Whole \_\_\_ Chopped \_\_\_ Ground \_\_\_ Pureed

Please send/label enough shirt protectors (adult sized bibs) and thickener to adequately meet the week's needs if normally used.

Special Diet? Explain: \_\_\_\_\_

**DRINKING:** \_\_\_ Independent \_\_\_ Some Assistance \_\_\_ Complete Assistance

Does the kamper drink any high calorie shakes to supplement his/her diet? Yes No (Please label and send with the kamper)

**USES ADAPTIVE EQUIPMENT DURING MEALS:** Yes No Explain: \_\_\_\_\_

(Please be sure to send and label all adaptive equipment.)

**PROBLEMATIC SEXUAL BEHAVIOR:** \_\_\_ Never \_\_\_ Sometimes \_\_\_ Often Explain: \_\_\_\_\_

Please note: If you have a kamper with special needs all of the above information must be filled out, thank you.



# Kamp Kiwanis®

## 2008 Medical Examination

IT IS INSUFFICIENT TO ATTACH YOUR OWN HEALTH RECORD, THIS FORM MUST BE COMPLETED IN FULL IN ORDER TO ATTEND KAMP KIWANIS

To be filled out by a Licensed Physician, Physician's Assistant or Nurse Practitioner representing the Licensed Physician  
2007 MEDICAL EXAMINATION (DOCTOR TO COMPLETE):

Name \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 BP \_\_\_\_\_ P \_\_\_\_\_ Vision R20/ \_\_\_\_\_ L20/ \_\_\_\_\_ Ears \_\_\_\_\_ Throat \_\_\_\_\_ Teeth \_\_\_\_\_ Skin \_\_\_\_\_  
 Respiratory \_\_\_\_\_ Cardiovascular \_\_\_\_\_ Musculoskeletal \_\_\_\_\_ Neurological \_\_\_\_\_  
 Liver \_\_\_\_\_ Spleen \_\_\_\_\_ Genitalia \_\_\_\_\_ Hernia \_\_\_\_\_ U/A \_\_\_\_\_ Asthma \_\_\_\_\_

The patient is under the care of a physician for the following condition(s): \_\_\_\_\_  
 Comments: \_\_\_\_\_

**COMPLETED IMMUNIZATIONS:** Polio: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_  
 DPT: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_ #5 \_\_\_\_\_ Tetanus: \_\_\_\_\_  
 MMR #1 \_\_\_\_\_ MMR #2 \_\_\_\_\_ HBV #1 \_\_\_\_\_ HBV #2 \_\_\_\_\_ HBV #3 \_\_\_\_\_  
 Vervax: #1 \_\_\_\_\_ #2 \_\_\_\_\_ (or History of Chicken Pox: Yes \_\_\_\_\_ No \_\_\_\_\_ ) TB Test: date/results): \_\_\_\_\_  
 HiB #1 \_\_\_\_\_ HiB #2 \_\_\_\_\_ HiB #3 \_\_\_\_\_ HiB #4 \_\_\_\_\_

**INDIVIDUALIZED ORDERS:** The following Standard Over the Counter/PRN Medications are available in the Health Center to be administered by a Licensed Professional. The family physician must indicate **Yes / No** to the administration of *each* PRN medication listed below **or we will not be able to administer the medication during the Kamper's stay.**

MEDICATION	DOSAGE/SCHEDULE	AGREE WITH ORDER	COMMENTS
Pain reliever/fever reducer:			
Acetaminophen/Ibuprofen	per label instructions by age/weight	Yes / No	_____
Auralgan (Ear Drops)	per label instructions by age/weight	Yes / No	_____
Cough Suppressants	per label instructions by age/weight	Yes / No	_____
Antacids	per label instructions by age/weight	Yes / No	_____
Bismuth Subsalicylate (Pepto-Bismol)	per label instructions by age/weight	Yes / No	_____
Decongestants (Sudafed)	per label instructions by age/weight	Yes / No	_____
Diphenhydramine (Benadryl)	per label instructions by age/weight	Yes / No	_____
Topical Antibiotics:			
Bacitracin/Neosporin/Bactroban	per label instructions	Yes / No	_____
Topical Antipruritics:			
Calagel/Hydrocortisone/Benadryl	per label instructions	Yes / No	_____

**PRESCRIPTION MEDICATIONS:** Please complete with patient's current regimen for both scheduled and PRN medications; please use additional paper if needed.

DRUG	ROUTE	DOSAGE	Time taken/SCHEDULE	COMMENTS
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____

**ADDITIONAL ORDERS:** As deemed necessary by health care provider to be implemented (i.e. peak flows nebuliser treatments, , blood draws/lab work, diabetic testing, insulin administration, dressing changes, via GT, etc.) \_\_\_\_\_

**LIMITATIONS ON ACTIVITY:**

Swimming \_\_\_\_\_ Hiking \_\_\_\_\_ Athletics \_\_\_\_\_ Canoeing \_\_\_\_\_ Other: \_\_\_\_\_  
 Explain above: \_\_\_\_\_

I certify that I have on this date examined the above named and that on the basis of my examination and medical history as furnished to me, I have found no reason which would make it medically inadvisable for the kamper to participate in physically strenuous activities.

**Physician's Signature** \_\_\_\_\_ Date \_\_\_\_\_ Date of Examination \_\_\_\_\_

**Please Print: Physician's Name** \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_