



P.O. Box 287 Mentone, AL 35984
(256) 634-4001 (800) 448-9279

**THIS FORM MUST BE COMPLETED
AND RETURNED BY JUNE 1ST.**
Immunization Record on Page 3 to be
completed by Parent or Physician's Office.
Pages 1 and 2 to be completed by Parent.
Page 3 to be completed by Physician.

Cabin: _____
Session: _____
Year: _____
OFFICE USE ONLY

Sessions Attending 1, 2, 3, 4, A, B, C (please circle)
Camper arriving by: CAR BUS PLANE (please circle)
Sex _____ Age _____ Height _____ Weight _____

Name: _____ Birth Date: _____ Years at Skyline _____

Parent or Guardian: _____ Phone (____) _____

Home Address: _____

Street Number _____ City _____ State _____ Zip Code _____
Sister(s) who attend Camp Skyline: _____ Age(s): _____

Mother's Occupation: _____ Work Phone (____) _____ Home Phone (____) _____ Cell Phone (____) _____

Father's Occupation: _____ Work Phone (____) _____ Home Phone (____) _____ Cell Phone (____) _____

In an emergency, please notify: _____ Phone (____) _____

If **NOT** available in an emergency, notify: _____ Address: _____ Phone (____) _____

Name of Family Physician: _____ Phone (____) _____

Name of Dentist/Orthodontist: _____ Phone (____) _____

Name of Optomologist/Optometrlist: _____ Phone (____) _____

Date of last physical examination by a Physician: _____ Please give name of Physician: _____ Phone (____) _____

Do you carry family medical/hospital insurance? If so, indicate: Carrier _____ Policy or Group No. _____

INSURANCE: ACCIDENT INSURANCE is included in the camp fee. This is not a deductible policy. ANY DOCTOR OR DRUGGIST BILLS INCURRED AS A RESULT OF ILLNESS WILL BE MAILED DIRECTLY TO THE PARENTS OR DEDUCTED FROM THE CAMPER'S SPENDING ACCOUNT.

Operations or serious injuries (dates): _____

Chronic or recurring illness or medical condition: _____

Current medications: (complete camper medication record): _____

Diet restrictions: _____

PARENT ITINERARY:

If you as a parent or guardian plan to be out of town while your child is at camp, please indicate your complete itinerary below and numbers where you can be reached.

Date	Place	Phone

Camp Nurse initial please after review of form: _____
Review Date: _____

<p>IMPORTANT – MUST BE COMPLETED FOR ATTENDANCE</p> <p>This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the Camp Director to provide routine health care, dispense medications, to order x-rays, routine tests and to release any records necessary for insurance purposes, and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp, or faxed if necessary.</p> <p>SIGNATURE OF PARENT OR GUARDIAN OR ADULT CAMPER/STAFFER _____ Date _____</p> <p>Witness _____ Date _____</p> <p>I also understand and agree to abide with the restrictions placed on my camp activities. Signature of minor or adult camper/staffer _____ Date _____</p> <p><small>*If for religious reasons you cannot sign this, then the camp should be contacted for legal waiver which must be signed for attendance.</small></p>
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HEALTH HISTORY
(Please Check and Give Approximate Dates)

Hearing Impaired _____	Bedwetting _____	Sleepwalking _____
Frequent Ear Infections _____	Frequent Colds _____	Diabetes _____
Frequent Sore Throats _____	Hypertension _____	Sinusitis _____
Heart Defect/Disease _____	Convulsions/Epilepsy _____	Bronchitis _____
Bleeding/Clotting Disorders _____	Kidney Trouble _____	Stomach Upset _____
Rheumatic Fever _____	Constipation _____	Fainting _____
Mononucleosis _____	Athlete's Foot _____	Hernia _____
Sprains or Breaks _____	Emotional Disturbance (Explain) _____	

ALLERGIES:

Asthma _____

Hay Fever _____ Other Drugs _____

Ivy Poisoning _____

Insect Stings _____ Other Foods _____

Penicillin _____

Other (Specify) _____

DISEASES: (List Dates)

Chicken Pox _____ Measles _____

German measles _____

Mumps _____ Asthma _____

Tuberculosis _____

Other (Specify) _____

CONDITION OF:

Eyes _____	Teeth _____
Glasses _____ Contacts _____	Braces _____ Retainer _____
What procedures should be taken if lost or broken at camp? _____	What procedures should be taken if lost or broken at camp? _____

Any dietary modifications required? _____

Any current medication required? (send with instructions) _____

Any other diseases or details of above? _____

FOR GIRLS: Has this person menstruated? _____ If not, has she been informed about it? _____

If so, is her menstrual history normal? _____

IMPORTANT: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp.

Suggestions on health related information for camp personnel: _____

Is there any camp activities from which the camper/staff should be exempt for health reasons? _____

IMMUNIZATION HISTORY

To be completed by Physician's Office or Parent

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria	1	1
Pertussis (Whooping Cough)	2	2
Tetanus	3	
Or *DPT		
Tetanus	1	
Diphtheria	2	
Or *TD		
Tetanus		
Oral Polio (Sabin) *TOPV		
Injectable Polio (Salk)		
Measles (hard, red, Rubeola)		
Mumps		
Rubelia (German measles, 3 day measles)		
Other		
Tuberculin test give _____ (most recent)		
Haemophilus Influenza b (HIB)		
Hepatitis B		

TO ATTEND CAMP A HEALTH EXAMINATION WITHIN THE PAST 12 MONTHS IS REQUIRED

Health Care Recommendations by Licensed Physician

Camper Name _____

Date Examined _____

I have examined the above camp applicant within the past year.

In my opinion the applicant's condition does does not permit his/her participation in an active camp program.

Height _____ Weight _____

Blood Pressure: _____

Does applicant have diabetes? Yes No

Does applicant have epilepsy? Yes No

The camper is under the care of a physician for the following condition(s):

Condition	Current Medication	If to be continued at camp, specify dosage or treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Explanation of any reported loss of consciousness, convulsion or concussion: _____

Medically prescribed meal plan or dietary restrictions: _____

Allergies (food, drugs, plants, and insects, etc.) Indicate special treatment required: _____

Additional health information: _____

LICENSED PHYSICIAN'S SIGNATURE _____			
Address _____	City _____	State _____	Phone _____
Number & Street _____	By _____	Zip Code _____	
Date of Form Completion _____			
*initial if completed by Nurse of Physician's Assistant.			

Within 24 hours of arrival at camp examine
And assess total health status of camper:

- _____ Cuts, scratches, or other lesions
- _____ Examined ears and throat for redness, swelling or discharge
- _____ Examined ears, neck, and throat for tenderness and masses
- _____ Examined hair for evidence of pediculosis
- _____ Evaluated overall ability to participate in camp activities
- _____ Weight
- _____ Other _____

OBSERVATION: (problems only)

Special physical observations and/or pertinent comments: _____

Screening Date _____

Screened by: Camp Health Supervisor _____

Record of any medications brought to camp: _____

Medications returned to camper: _____

INDIVIDUAL PATIENT RECORD

Date	Nature of Illness	Time	Parents Notified?	Treatment or Disposition

Other comments: _____