

Stone Mountain Adventures Medical History

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The information given on this form is gathered to assist us in identifying appropriate care. This form is to be completed by the parent(s)/guardian(s) of minors .

Last Name _____ First Name _____ Middle Initial ____
Birth date _____ Gender: _____ SS# _____ (required by hospital for billing)
Name: Custodial parent/guardian _____ Home Phone _____

Cell Phone# _____ Parent/Guardian SS# _____ (required by hospital for billing)

Second parent/guardian: emergency contact: _____

Home Phone # _____ Cell Phone# _____

If not available in an emergency, notify: Print Name _____ Relationship _____

Home Phone # _____ Cell Phone# _____

Family Physician's name: _____ Phone# _____

Family Dentist's name: _____ Phone# _____

INSURANCE INFORMATION: (or include photo-copy of Ins. Card - both sides)

Is the participant covered by family medical/hospital insurance? _____ YES _____ NO

Carrier and plan name _____ Group # _____

Carrier address _____ Phone# _____

Name of insured _____ Insurance ID # _____

HEALTH HISTORY

The following information must be completed by a parent/guardian. The intent of this information is to provide camp health care personnel with the background to provide appropriate care as needed. It is important that you keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Please provide complete and detailed information so that we can be aware of camper needs.

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

Food allergies (list)

Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire duration of camp stay. Keep it in the original packaging/bottle that identifies the prescribing physician (prescription drug), the name of the medication, the dosage, and the frequency of administration.

The Participant takes no medications on a routine basis. _____

The Participant takes medications as follows:

Med #1 _____ Dosage _____ Specific time taken daily _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific time taken daily _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific time taken daily _____

Reason for taking _____

Attach additional pages for more medications.

Please identify any medications taken during the school year that the participant does not / may not take during the summer: _____

RESTRICTIONS: The following restrictions apply to the participant:

Dietary Restrictions	_____ Does not eat eggs
_____ Does not eat red meat	_____ Does not eat dairy products
_____ Does not eat poultry	_____ Other
_____ Does not eat pork	_____
_____ Does not eat seafood	_____

Activity Restrictions (i.e. what cannot be done at camp, what adaptations or limitations are necessary)

General Questions (Please explain any "yes" answers)

Has / Does the participant:

1. Had any recent injury, illness, or infectious disease? _____ Y _____ N
2. Have a chronic or recurring illness/condition? _____ Y _____ N
3. Have frequent headaches? _____ Y _____ N
4. Had a head injury? _____ Y _____ N
5. Have been knocked unconscious? _____ Y _____ N
6. Wear glasses, contacts, or protective eye wear? _____ Y _____ N
7. Ever had frequent ear infections? _____ Y _____ N
8. Ever passed out during or after exercise? _____ Y _____ N
9. Ever been dizzy during or after exercise? _____ Y _____ N

10. Ever had seizures? _____ Y _____ N
11. Ever had chest pain during or after exercise? _____ Y _____ N
12. Ever had high blood pressure? _____ Y _____ N
13. Ever been diagnosed with a heart murmur? _____ Y _____ N
14. Ever had back problems? _____ Y _____ N
15. Ever had problems with joints (knees, ankles, etc.)? _____ Y _____ N
16. Had an orthodontic appliance being brought to camp? _____ Y _____ N
17. Have any skin problems (itching, acne, rash, etc.)? _____ Y _____ N
18. Have diabetes? _____ Y _____ N

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|---|--|
| 19. Have asthma?
_____ Y _____ N | 23. If female, have an abnormal menstrual history?
_____ Y _____ N |
| 20. Had mononucleosis in the past 12 months?
_____ Y _____ N | 24. Have a history of bed-wetting?
_____ Y _____ N |
| 21. Had problems with constipation/diarrhea?
_____ Y _____ N | 25. Ever had an eating disorder?
_____ Y _____ N |
| 22. Have problems with sleepwalking?
_____ Y _____ N | 26. Ever had emotional difficulties for which professional help was sought?
_____ Y _____ N |

For any “yes” answers please explain (noting the number) any relevant information on the back of this page

IMPORTANT - SIGNATURES REQUIRED FOR ATTENDANCE

Parent/Guardian Authorizations: This health history is correct and complete to the best of my knowledge. The person herein described has permission to engage in all camp activities except as indicated. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed medical form may be photocopied for trips out of camp or if deemed necessary.

Signature of Parent or Guardian _____ *Date* _____

Printed Name _____

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

Signature of camper _____ *Date* _____

