



**Health History and Examination Form  
for Children, Youth and Adults  
Attending Camp Merrie-Woode®**

Developed by American Camp Association  
with the American Academy of Pediatrics.  
Adapted for Camp Merrie-Woode®.

Camper     Staff  
 Dates of Camp Attendance:  
 June     Main     August    20\_\_\_\_  
 Mail this form to the following address by **May 1st**:  
**Camp Merrie-Woode®**  
 100 Merrie-Woode Road, Sapphire, NC 28774

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. 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 every year.

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_  
Last First Middle

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

Social security number of participant \_\_\_\_\_ Gender:  Male  Female

Custodial parent/guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home address (if different from above) \_\_\_\_\_  
Street Address City State Zip

Business address \_\_\_\_\_  
Street Address City State Zip Phone

Second parent or guardian or emergency contact \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip Phone

Business address \_\_\_\_\_  
Street Address City State Zip Phone

If not available in an emergency, notify \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

**Important – These boxes must be complete for attendance\***

**Insurance Information**

**1** Is the participant covered by family medical/hospital insurance?  Yes  No  
 If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

**\*\* 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 camp activities except as noted.

**2** I hereby give permission to the camp 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 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 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 represen-

tatives" 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 camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the camp 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 or guardian or adult camper/staffer \_\_\_\_\_  
 Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**3 Disclosure of Medical Information/HIPPA** I authorize the staff at Camp Merrie-Woode to divulge my medical information for the provision, coordination or management of health care and related services.

Name of patient \_\_\_\_\_  
 Signature of legal guardian \_\_\_\_\_

**4** I also understand and agree to abide by any restrictions placed on my participation in camp activities.  
 Signature of minor or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

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

## Health History

The following information must be filled in by the parent/ guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. 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. Provide complete information so that the camp can be aware of your 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 time at camp. Keep in the original packaging/bottle

that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

This person takes 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 _____ |              |                                     |

Attach additional pages for more medications.  
Identify any medications taken during the school year that participant does / may not take during the summer: \_\_\_\_\_

\_\_\_\_\_

### RESTRICTIONS

The following restrictions apply to this individual:

#### Dietary

|   |   |  |
|---|---|--|
| <input type="checkbox"/> Does not eat red meat  | <input type="checkbox"/> Does not eat pork    | <input type="checkbox"/> Does not eat eggs           |
| <input type="checkbox"/> Does not eat poultry   | <input type="checkbox"/> Does not eat seafood | <input type="checkbox"/> Does not eat dairy products |
| <input type="checkbox"/> Other (describe) _____ |   |  |

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

\_\_\_\_\_

\_\_\_\_\_



## Health Care Recommendations by Licensed Medical Personnel

I examined this individual on \_\_\_\_\_. (Camp Merrie-Woode requires annual exams)

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant  is  is not able to participate in an active camp program.

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

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## Recommendations and Restrictions at Camp

Treatment to be continued at camp \_\_\_\_\_

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

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Any medically-prescribed meal plan or dietary restrictions \_\_\_\_\_

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Known allergies \_\_\_\_\_

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Description of any limitation or restriction on camp activities \_\_\_\_\_

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Additional information for health care staff at Camp Merrie-Woode \_\_\_\_\_

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## ***Important – This box must be complete for attendance***

**Signature of Licensed Medical Personnel** \_\_\_\_\_

Printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

**5**

### *For camp use only*

#### **Screening Record**

Date screened \_\_\_\_\_ Time \_\_\_\_\_ am  
pm

Meds received \_\_\_\_\_

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Updates/additions to health history noted  Yes  No  None required

Current health needs identified \_\_\_\_\_

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Observation notes \_\_\_\_\_

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Screened by \_\_\_\_\_