

# Health History and Examination Form for Children, Youth and Adults Attending Plast Camps

Mail to the address below by June 15th

**Plast Camp – Novyi Sokil**  
c/o Roman Lewyckyj  
7194 Hertfordshire Way  
Victor, NY 14564

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.  
(This side to be filled by parents/guardian of minors or by adult campers/staff members themselves.)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
*Last First Initial*

Parent or Guardian (or Spouse) \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
*Street & Number City State ZIP Area/Number*

Business \_\_\_\_\_ Phone \_\_\_\_\_  
*Street & Number City State ZIP Area/Number*

Second Parent or Guardian or Emergency Contact \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
*Street & Number City State ZIP Area/Number*

Business \_\_\_\_\_ Phone \_\_\_\_\_  
*Street & Number City State ZIP Area/Number*

It not available in an emergency, notify

Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
*Street & Number City State ZIP Area/Number*

## Health History

(Check: Give approximate dates.)

- \_\_\_\_\_ Frequent Ear Infections
- \_\_\_\_\_ Heart Defect/Disease
- \_\_\_\_\_ Convulsions
- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Bleeding/Clotting Disorders
- \_\_\_\_\_ Hypertension
- \_\_\_\_\_ Mononucleosis
- Diseases
- \_\_\_\_\_ Chicken Pox
- \_\_\_\_\_ Measles
- \_\_\_\_\_ German Measles
- \_\_\_\_\_ Mumps
- Allergies (Dates not needed)
- \_\_\_\_\_ Hay Fever
- \_\_\_\_\_ Ivy Poisoning. etc.
- \_\_\_\_\_ Insect Stings
- \_\_\_\_\_ Penicillin
- \_\_\_\_\_ Other Drugs
- \_\_\_\_\_ Asthma
- \_\_\_\_\_ Other (Specify)

Operations or serious injuries (dates) \_\_\_\_\_

Chronic or recurring illness or medical condition \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

Current medications (send with instructions) \_\_\_\_\_

Other diseases \_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Do you carry family medical/hospital insurance?  Yes  No

If so, indicate: Carrier \_\_\_\_\_ Policy or Group # \_\_\_\_\_

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

Suggestions on health related information for camp personnel \_\_\_\_\_

For Female

Has this person menstruated? \_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_

If so, is her menstrual history normal? \_\_\_\_\_ Special Consideration \_\_\_\_\_

### Important -- This Box Must be Completed for Attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, 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. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver, which must be signed for attendance.

Name: \_\_\_\_\_ Date Examined: \_\_\_\_\_ Camp: \_\_\_\_\_ Year: \_\_\_\_\_

**Immunization History**

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	Yew of Last Booster
Diphtheria } Pertussis (Whooping Cough) } DPT* Tetanus } or	1 2 3	1 2
Tetanus } Diphtheria } TD* or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given _____ (most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		

**Health Care Recommendations by Licensed Physician**

I have examined the above camp applicant. Date Examined \_\_\_\_\_

In my opinion, the above's condition,  does  does not preclude his/her participation in an active camp program.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Current treatment (include current medications) \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion, or concussion \_\_\_\_\_

Does applicant have epilepsy?  Yes  No

Does applicant have diabetes?  Yes  No

**Recommendations and Restrictions While at Camp**

Any treatment to be continued at camp \_\_\_\_\_

Any medication to be administered at camp (specific dosages) \_\_\_\_\_

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

Any allergies (food, drugs, plants, insects, etc.) \_\_\_\_\_

Activities to be encouraged or limited \_\_\_\_\_

Additional health information \_\_\_\_\_

Licensed Physician's Signature \_\_\_\_\_

Address \_\_\_\_\_  
*Street & Number City State ZIP Area/Number*

Date of Form Completion \_\_\_\_\_ \*By \_\_\_\_\_

*\*Initial if completed by nurse or physician's assistant*