2017 Health History and Enrollment for Sam Davis Youth Camp for Youth and Adults

- Complete this form in ink answering all questions.

Please print legibly

- The parent/guardian and camper both must sign this form.
- Mail to SDYC/SCV, P.O. Box 59 , Columbia, TN 38402
- No one will be allowed to attend a Sam Davis Youth Camp

without this completed form received at least 2 weeks before Camp
USE ADDITIONAL PAPER FOR ANSWERS IF NECESSARY

The information on this form is gathered to assist Sam Davis Youth Camp in identifying appropriate care. Health history must be filled out annually by parents/guardians of minors or by adults themselves who serve as camp volunteer, counselor, staff or employee. Attach written documentation verifying health examination within two years from approved licensed medical personnel or have the Health Examination Portion completed and signed by same.

Dates of Camp Attendance VA 18-23 JUNE_____; TX 9–15 JULY _____

Please check appropriate box: □Youth Member(age 12-18) □ Volunteer/Counselor □ Staff/Employee
Gender: □ M □ F □ Junior Counselor (19-21)

Participant's Full Name _____ Preferred Name _____

Birth Date _____ Age during Camp _____

Address _____
Street Address City State Zip

Custodial Parent or Guardian_____

Home Address _____ Phone( )_____
Street Address City State Zip

Parent/Family e-mail_____ Mobile( )_____

Business _____ Phone( )_____
Name of Company Street Address City State Zip

Second Parent or Guardian_____

Home Address _____ Phone( )_____
Street Address City State Zip

Parent/Family e-mail _____ Mobile( )_____

Business_____ Phone( )_____
Name of Company Street Address City State Zip

If Parent(s) or Guardian not available in an emergency, notify:

Name _____ Relationship _____

Address _____ Phone( )_____
Street Address City State Zip

Mobile( )_____

Insurance Information

Is the member (camper) covered by family health/medical/hospital insurance? □ Yes □ No

Health Insurance Carrier _____ Group/Policy No. _____

Health Insurance Address _____ Phone ( ) _____
Street Address City State Zip

Name of Insured _____ Relationship to Member (camper) _____

Physician/Dentist Information

Physician's Name _____ Phone ( ) _____
Street Address City State Zip

Dentist's Name _____ Phone ( ) _____
Street Address City State Zip

Allergies/Dietary Restrictions

List all known Allergies to medication, food, other (including insect stings, hay fever, penicillin, animal dander, plant allergies, etc.)

_____

Any medical or religious meal plan or dietary restriction: □ Yes □ No Explain: _____

_____

_____

Immunizations: (must be completed or attach Immunization Record)

Date of last Tetanus shot _____

Which of the following has the participant had?	Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
□ Measles	DTP	____	____	____	____	____	____
□ Chicken Pox	TD (tetanus/diphtheria)	____	____	____	____	____	____
□ German Measles	Tetanus	____	____	____	____	____	____
□ Mumps	Polio	____	____	____	____	____	
□ Hepatitis A	MMR	____	____				
□ Hepatitis B	or Measles	____	____				
□ Hepatitis C	or Mumps	____	____				
	Or Rubella	____	____				
TB Mantoux Test	Haemophilus influenza B	____	____	____	____		
Date of last test _____	Hepatitis B	____	____	____			
Result: □ Positive □ Negative	Varicella (Chicken Pox)	____	____				

List approximate date if participant has had or has been exposed to:

Chicken Pox _____ Tuberculosis _____ Measles _____

If immunizations are not up-to-date, please explain: _____

_____

My child has not had any immunizations due to parental religious beliefs and/or other beliefs □ Yes □ No

_____

Medications
Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last entire time at camp. All prescription medications must be in original bottle, identifying prescribing physician (if a prescription drug), showing name of medication, dosage, and frequency of administration.

□ This person takes medications as follows:
Med #1 _____ Dosage _____ Specific Time _____

Reason _____

Med #2 _____ Dosage _____ Specific Time _____

Reason _____

Med #3 _____ Dosage _____ Specific Time _____

Reason _____

□ This person takes NO medications on a routine basis.

Sam Davis Youth Camp is hereby granted permission to administer the following over-the-counter medications if the designated camp medical personnel deems it necessary Dosages will be administered to directions on the bottle unless a physician directs otherwise.

Headache……Tylenol/Ibuprophen/Aleve……□ Yes □ No
Bites/Rashes……Antihistimine/(Benadryl/Claritin)……..……□ Yes □ No
Upset Stomach……Pepto Bismol/Tums/Rolaids……□ Yes □ No
Diarrhea……Immodium AD……□ Yes □ No
Menstrual Cramps……Ibuprophen or Aleve……□ Yes □ No
Poison Ivy……..Calamine Lotion or CortAid……□ Yes □ No
Ear Infection from Swimming……..Swim Ear–Rx……...□ Yes □ No
Coughing……Robitussin Cough Syrup……..□ Yes □ No

General Health Height _____ Weight _____

(Explain "yes" answers below)
Has/does the participant:

1. Had any recent injury, illness or infectious diseases, Measles, mumps, mononucleosis? □ Yes □ No
2. Have a chronic or recurring illness or condition ear infections, heart condition? □ Yes □ No
3. Had any loss of consciousness, convulsion, Or concussion? □ Yes □ No
4. Have any medically prescribed meal plan or Dietary restrictions? □ Yes □ No
5. Have any bleeding or clotting? □ Yes □ No
6. Have hypertension? □ Yes □ No
7. Have hepatitis? □ Yes □ No
8. Have asthma? □ Yes □ No
9. Have epilepsy? □ Yes □ No
10. Have diabetes? □ Yes □ No
11. Had chicken pox? □ Yes □ No
12. If female, have an abnormal menstrual history? □ Yes □ No
13. Wear glasses, contacts or protective eye wear? □ Yes □ No
14. Currently under physician's care? □ Yes □ No

Explain any "yes" answers, noting the number of the question. _____
_____
_____

Check below if participant is subject to:

____Frequent Sore Throats
____Headaches
____ Fainting
____ Sleep Walking
____ Sinusitis
____ Frequent Colds
____ Convulsions
____ Kidney Trouble
____ Athlete's Foot
____ Diarrhea
____ Epileptic Seizures
____ Constipation
____ Heart Trouble
____ Bronchitis Cramps
____ Ear Infections
____ Home Sickness
____ Bed Wetting

Other – Specify _____
_____
_____

Mental, Emotional and Psychological Health
Has/does the participant:

1. Have an emotional health concern that will impact Camp participation? ……..□ Yes □ No
2. Have a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder? …….□ Yes □ No
3. Have a significant life event that continues to affect the camper's life/health?.....□ Yes □ No
4. Use an individualized learning plan at school?..... □ Yes □ No
5. Diagnosed or treated for Attention Deficit Disorder (ADD)……□ Yes □ No

Information about participant's physical, emotional, or mental health behavior, including sexual abuse, depression or suicide, of which the camp should be aware:

_____

_____

_____

Does the Participant have a Criminal/Juvenile Record or serious school disciplinary record? □ Yes □ No
If yes, please explain_____

_____

Health Examination by Licensed Medical Physician, Physicians Assistant or (in some states*) Certified Nurse Practitioner
*Check with your state health department to determine if a certified nurse practitioner is considered "licensed medical personnel."

Date of examination:_____

I have examined the camp applicant and, in my opinion, he/she □ is □ is not able to participate in an active camp program.

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

_____

Recommendations and Restrictions at Camp for Health Reasons

Description of any limitation or restriction on camp activities: _____

_____

Treatment to be continued at camp: _____

_____

Signature of Licensed Medical Personnel _____ Title _____

Doctor's Office/Clinic _____ Phone _____
Street Address City State Zip

- It is understood that all Sam Davis Youth Camp members in attendance will abide by the rules of the lodge and camp. If any member does not, the privileges of participating in the activities will be taken away; or in the case of a serious violation, the member will be returned home.
- By signing this form, I verify my child (camper) is at least 12 years of age.
- **This health history is complete and correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. False, misleading, deliberately incomplete answers or failure to disclose a serious or serious condition that affects the camper, counselors or others at the camp, is grounds to dismiss a camper or counselor from Camp. For Camper, picking up the dismissed camper is the responsibility of the parents/guardians.**

Personal Release: I hereby irrevocably grant to Sam Davis Youth Camp the right to use, publish or distribute my and/or my child's image, name, voice and/or likeness, in whole or in part, for the purposes of promotion, education or marketing use by Sam Davis Youth Camp. I waive the right to inspect, approve or be compensated for the use to which it may be applied. I release Sam Davis Youth Camp for myself, my heirs, and executors, from all claims, demands or liabilities that may arise regarding the use of my and/or my child's image, name, voice or likeness. I have read and understand this Personal Release.

Emergency Authorization: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for me as a volunteer, counselor, staff or employee, or my child in the event I cannot be reached in an emergency. I herby give permission to the physician selected by the damp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child (or myself) as named above, if my child needs treatment for illness or injury which requires that he/she be taken from the camp to seek medical treatment. I understand that I will be notified immediately by the camp director or designee.

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) t 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.

_____ _____ _____

Parent/Guardian Parent/Guardian Date

- I understand and agree to abide by the rules and restrictions placed on my camp activities _____

Signature of Youth Member

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