Health History and Examination Form

For Children, Youths and Adults Attending Camp

Print and complete this form, or replace it with a physical exam or well-child check-up done within the previous year. Scan and email your document to: info@hillcountryequestlodge.com, or mail it to: Hill Country Equestrian Lodge, 1580 Hay Hollar Road, Bandera TX 78003 by June 1.

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. The first three pages must be filled out by the parents or guardians of minors or by adults themselves.

Page 4 requires the signature of a medical professional.

An updated health history is required every two years. If there are no changes in camper's health history from the previous year, an email or letter from a parent or guardian stating such is all that is necessary.

Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address

_____
Street City State Zip

Social Security number _____

1st Parent _____ 2nd Parent_____
Address_____ Address_____
_____ _____
Home phone _____ Home phone_____
Work phone _____ Work phone_____
Cell phone _____ Cell phone _____
E-mail _____ E-mail_____

Insurance Information

◆ A photocopy of the front and back of the health insurance card must be attached to this form.

Carrier or plan name _____ Group #_____

IMPORTANT. These boxes must be completed for attendance.*

To the best of my knowledge, this health history is correct and complete.The person named above has permission to engage in all camp activities, except as noted.

I hereby give my 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 named above is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" 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 named above, 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 represen-tatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physican 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 _____

Printed name _____ Date_____

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 form, 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 or guardian. It is intended to provide camp personnel with sufficient 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 personnel upon the participant's arrival at camp.

◆ It is important to provide complete information so that the camp can respond correctly to your child's /your needs.

Allergies

List all known

Medication allergies — Describe reaction and management of the reaction.

_____ _____
_____ _____
_____ _____

Food allergies

_____ _____
_____ _____
_____ _____

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

_____ _____
_____ _____
_____ _____

Medications

Please list all medications, including over-the-counter or non-prescription drugs, that are taken routinely. Bring enough medication to last the entire camp session. If using a prescription drug, please keep in the original packaging or labeled bottle that identifies the prescribing physician, the name of the medication, the dosage and the frequency of administration.

☐ This person takes no medications on a regular basis.
☐ This person takes the following medications:

Medication _____ Dosage _____ Frequency_____
Reason for taking _____
Medication _____ Dosage _____ Frequency_____
Reason for taking_____
Medication _____ Dosage _____ Frequency_____
Reason for taking _____

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

_____

Restrictions

The following restrictions apply to this participant:

Dietary

☐ Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs
☐ Does not eat poultry ☐ Does not eat seafood ☐ Does not eat dairy products
☐ Other

_____
_____
_____

Activity

Explain what cannot be done or needs to be adapted or limited for this participant:

_____
_____
_____

General Questions

Explain 'yes' answers below.

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐	16. Ever had back problems?	☐	☐
2. Have a chronic or recurring illness /condition?	☐	☐	17. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
3. Ever been hospitalized?	☐	☐	18. Have an orthodontic appliance being brought to camp?	☐	☐
4. Ever had surgery?	☐	☐	19. Have skin problems (e.g., itching, rash, acne)?	☐	☐
5. Have frequent headaches?	☐	☐	20. Have diabetes?	☐	☐
6. Ever had a head injury?	☐	☐	21. Have asthma?	☐	☐
7. Ever been knocked unconscious?	☐	☐	22. Had mononucleosis in the past 12 months?	☐	☐
8.Wear glasses, contacts or protective eyewear?	☐	☐	23. Had problems with diarrhea/constipation?	☐	☐
9. Ever had frequent ear infections?	☐	☐	24. Have problems with sleepwalking?	☐	☐
10. Ever passed out during or after exercise?	☐	☐	25. If female, have an abnormal menstrual history?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐	26. Have a history of bed wetting?	☐	☐
12. Ever had seizures?	☐	☐	27. Ever had an eating disorder?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐	28. Ever had emotional difficulties for which professional		
14. Ever had high blood pressure?	☐	☐	help was sought?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐			

Please explain any 'yes' answers, noting the number of the question(s):

_____
_____
_____

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken pox
- ☐ German measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

TB Mantoux Test
Date of last test _____
Result : ☐ Positive ☐ Negative

Please give all dates of immunization for:

Vaccine	**Mo/ Yr**	**Mo/ Yr**	**Mo/ Yr**	**Mo/ Yr**	**Mo/ Yr**	**Mo/ Yr**
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diptheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
MMR	_____	_____	_____	_____	_____	_____
or Measles	_____	_____				
or Mumps	_____	_____				
or Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Varicella (chicken pox)	_____	_____				

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware:

_____
_____
_____
_____
_____

Name of family physician_____ Phone _____
Address_____
Street City State Zip

Name of participant's dentist /orthodontist _____ Phone _____ _____
Address_____
Street City State Zip

Health Care Recommendations by Licensed Medical Personnel

I examined _____ on _____
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:
_____
_____
_____

Recommendations and Restrictions at Camp

Treatment to be continued at camp:
_____
_____
_____

Medications to be administered at camp (name, dosage, frequency):
_____
_____
_____

Any medically-prescribed meal plan or dietary restrictions:
_____
_____
_____

Known allergies:
_____
_____
_____

Description of any limitation or restriction on camp activities:
_____
_____
_____
_____

Additional information for health care staff at the camp:
_____
_____
_____

Signature of Medical Personnel

Signature _____ Date _____

Name printed _____ Title _____

Address _____ Phone _____ _____
Street City State Zip