

**CAMP HONOR - CAMPER HEALTH HISTORY FORM 2022**

Page 1 of 2

Name \_\_\_\_\_  
Last First Middle Initial DOB \_\_\_\_\_

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

Guardian Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Gender:  Male  Female

**EMERGENCY** Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

If above contact person not available in an emergency, notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

**Insurance Information**

Are you covered by medical insurance?  Yes  No If Yes, complete the following:

Insurance Company Name \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Policy holder \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

Policy # \_\_\_\_\_ Group #/ Plan # \_\_\_\_\_ Physician Name \_\_\_\_\_

**Medical Release**

In case of medical and/or surgical emergency, I authorize Camp HONOR medical staff to render or to arrange for my child (print full name) \_\_\_\_\_ to receive any x-ray, anesthetic, medical, dental, surgical procedure, treatment and hospital care which is deemed advisable by and is to be rendered under the supervision of any physician, dentist or surgeon licensed in Arizona.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**—Complete This Box For Campers With Bleeding Disorders—**

Type of Bleeding Disorder: VIII IX VWD Other \_\_\_\_\_ Level/Severity \_\_\_\_\_

Current Transfusion Product \_\_\_\_\_

Life-threatening Bleeds \_\_\_\_\_ Units Major Bleeds \_\_\_\_\_ Units Minor Bleeds \_\_\_\_\_ Units

Home Infusion? \_\_\_Yes \_\_\_No Describe any Target Joints \_\_\_\_\_

Inhibitor? \_\_\_No \_\_\_Yes – If yes, Last Titer and date \_\_\_\_\_ Immune Tolerance \_\_\_No \_\_\_Yes Are

you on Prophylaxis? \_\_\_No \_\_\_Yes – If Yes Dose and Schedule \_\_\_\_\_

Do you have a Central Line? \_\_\_No \_\_\_Yes – If Yes What Type? \_\_\_\_\_

Hepatitis B Antigen \_\_\_Pos \_\_\_Neg Hepatitis B Surface Antibody \_\_\_Pos \_\_\_Neg Hepatitis C \_\_\_Pos \_\_\_Neg

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Page 2 of 2

Name \_\_\_\_\_  
Last First Middle Initial DOB

The following information must be completed by the parent/guardian. The intent of this information is to provide camp medical staff background information to provide appropriate care and be aware of your needs.

**ALLERGIES** List all known Describe reaction and previous management

Medication allergies (list)

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Food allergies or Restrictions (list)

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |

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

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |

## MEDICAL CONDITIONS

HIV \_\_\_ Heart Disease \_\_\_ Kidney Disease \_\_\_ Asthma \_\_\_ Seizure Disorder \_\_\_ Diabetes \_\_\_ High blood Pressure \_\_\_

Please Explain Any Significant Medical History \_\_\_\_\_

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## MEDICATIONS

Please list All medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it 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.

### List Medications

| Drug Name | Dose | Schedule | Reason for Taking |
|-----------|------|----------|-------------------|
|-----------|------|----------|-------------------|

|       |       |       |       |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

## HIPPA RELEASE STATEMENT

(Medical Privacy)

I authorize the medical staff of CAMP HONOR to release my child's medical information to his/her camp counselor and their supervisors. I understand that my child's medical information is shared with these staff members so that they can provide the best care and experience for my child while at camp.

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

**CAMP HONOR – CAMPER MEDICAL FORM 2022**

Page 1 of 2

Name \_\_\_\_\_  
Last
First
Middle Initial
 DOB \_\_\_\_\_

I have examined the above participant. Date of last examination \_\_\_\_\_

Weight \_\_\_\_\_ BP \_\_\_\_\_/\_\_\_\_\_ Pulse \_\_\_\_\_

**MEDICAL CONDITIONS**

Heart Disease \_\_\_\_ Kidney Disease \_\_\_\_ Asthma \_\_\_\_ Seizures \_\_\_\_ Hemophilia or VWD \_\_\_\_ HIV \_\_\_\_ Diabetes \_\_\_\_

Other: \_\_\_\_\_

Allergies: \_\_\_\_\_

Any recent significant illnesses, injuries, infections or hospitalizations: \_\_\_\_\_

**—PHYSICIANS Complete This Box For Campers With Bleeding Disorders—**

Type of Bleeding Disorder: VIII IX VWD Other \_\_\_\_\_ Level/Severity \_\_\_\_\_

Current Transfusion Product \_\_\_\_\_

Life-threatening Bleeds \_\_\_\_\_Units Major Bleeds \_\_\_\_\_Units Minor Bleeds \_\_\_\_\_Units

Home Infusion? \_\_\_\_Yes \_\_\_\_No Describe any Target Joints \_\_\_\_\_

Inhibitor? \_\_\_\_No \_\_\_\_Yes – If yes, Last Titer and date \_\_\_\_\_ Immune Tolerance \_\_\_\_No \_\_\_\_Yes

Prophylaxis? \_\_\_\_No \_\_\_\_Yes – If Yes Dose and Schedule \_\_\_\_\_

Central Line? \_\_\_\_No \_\_\_\_Yes – If Yes What Type? \_\_\_\_\_

Hepatitis B Antigen \_\_\_\_Pos \_\_\_\_Neg Hepatitis B Surface Antibody \_\_\_\_Pos \_\_\_\_Neg Hepatitis C \_\_\_\_Pos \_\_\_\_Neg

**PHYSICAL EXAM**

| <u>GENERAL</u> | <u>NORMAL</u> | <u>ABNORMAL</u> | <u>EXPLAIN ABNORMALITIES</u> |
|----------------|---------------|-----------------|------------------------------|
| Head & Neck    | _____         | _____           | _____                        |
| Eyes & Ears    | _____         | _____           | _____                        |
| Nose & Throat  | _____         | _____           | _____                        |
| Chest          | _____         | _____           | _____                        |
| Heart          | _____         | _____           | _____                        |
| Abdomen        | _____         | _____           | _____                        |
| Skin           | _____         | _____           | _____                        |
| Lymphatic      | _____         | _____           | _____                        |
| Neurological   | _____         | _____           | _____                        |
| Joints/Muscles | _____         | _____           | _____                        |

**CAMP HONOR – CAMPER MEDICAL FORM 2022**

Page 2 of 2

Name \_\_\_\_\_  
Last First Middle Initial

DOB \_\_\_\_\_

**Assessment and/or any other significant medical history/psychosocial history:**

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

**Limitations**

Activity restrictions \_\_\_\_\_

Diet restrictions \_\_\_\_\_

**Immunizations** Please attach immunization record

**MEDICATIONS**

Please list All medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it 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.

**List Medications**

| Drug Name | Dose  | Schedule | Reason for Taking |
|-----------|-------|----------|-------------------|
| _____     | _____ | _____    | _____             |
| _____     | _____ | _____    | _____             |
| _____     | _____ | _____    | _____             |
| _____     | _____ | _____    | _____             |
| _____     | _____ | _____    | _____             |
| _____     | _____ | _____    | _____             |
| _____     | _____ | _____    | _____             |

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

Signature of Provider \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Printed Name \_\_\_\_\_ Mailing address \_\_\_\_\_

Return to : Arizona Bleeding Disorders  
826 N 5<sup>th</sup> Ave  
Phoenix, AZ 85003

Fax: 602-955-1962