To Be Completed and Signed by Parent or Guardian

# CAMP HONOR - CAMPER HEALTH HISTORY FORM 2023



Name ____________________________________________ DOB ______________
Last First Middle Initial

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

# CAMP HONOR - CAMPER HEALTH HISTORY FORM 2023


Name ____________________________________________ DOB
Last First Middle Initial

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 ____________________________________________

## 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

**This form is to be completed by a Licensed Health-Care Practitioner**

# CAMP HONOR – CAMPER MEDICAL FORM 2023



Name ______________________________________________ DOB ________________
Last First Middle Initial

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

| GENERAL | NORMAL | ABNORMAL | EXPLAIN ABNORMALITIES |
|---|---|---|---|
| Head & Neck | _________ | ___________ | ______________________________ |
| Eyes & Ears | _________ | ___________ | ______________________________ |
| Nose & Throat | _________ | ___________ | ______________________________ |
| Chest | _________ | ___________ | ______________________________ |
| Heart | _________ | ___________ | ______________________________ |
| Abdomen | _________ | ___________ | ______________________________ |
| Skin | _________ | ___________ | ______________________________ |
| Lymphatic | _________ | ___________ | ______________________________ |
| Neurological | _________ | ___________ | ______________________________ |
| Joints/Muscles | _________ | ___________ | ______________________________ |

# CAMP HONOR – CAMPER MEDICAL FORM 2023



Name ______________________________________________ DOB ________________
Last First Middle Initial

**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 5th Ave
Phoenix, AZ 85003
Fax: 602-955-1962