CAMP LITTLE GIANT
HEALTH HISTORY AND EXAMINATION FORM

Section I. To be completed by parents/guardians of minors or by adult campers/staff members. We must have both forms 2 weeks prior to the starting date of the camp session, thank you for your promptness.

Name:_____ **Date of Birth**_____ **Sex**_____ **Age** _____
Last First

Parent, Guardian, or Spouse_____ (____) _____
cell

Home Address_____ (____) _____
Number & Street City State Zip Telephone

Business_____ (____) _____
Number & Street City State Zip Telephone

Second Parent or Guardian_____ (____) _____
cell

Home Address_____ (____) _____
Number & Street City State Zip Telephone

Business_____ (____) _____
Number & Street City State Zip Telephone

IF NOT AVAILABLE IN AN EMERGENCY NOTIFY:

Name _____ (____) _____
Address_____ (____) _____
Number & Street City State Zip Telephone

HEALTH HISTORY

Give approximate dates on all that applies

		Diseases	**Allergies**	
_____Frequent Ear Infections	_____Convulsions	_____Chicken Pox	_____Hay Fever	_____Asthma
_____Heart Defect Disease	_____Diabetes	_____German measles	_____Penicillin	_____Food
_____Hypertension		_____Mumps	_____Other Drugs	
_____Bleeding/Clotting Disorders		_____Measles	_____Insect Stings	
_____Psychiatric Treatment		_____Other	_____Ivy Poisoning, etc.	
_____Other			_____Other (see below)	

Operations or serious injuries (Dates)_____
Disability or chronic or recurring illness_____
Special Diet or supplement _____
Other Diseases or details of above _____
_____

DOES CAMPER/STAFF TAKE MEDICATION REGULARLY? Yes _____ No _____
An adequate supply of current medications must be sent with the camper along with detailed instructions.
Bring all original bottles with dosages or script from Physician

HAS THE CAMPER/STAFF EVER HAD A SEIZURE? Yes _____No _____
Approximate date of last seizure: _____
What usually causes the seizure? _____
Describe behavior before and after a seizure: _____
_____

Name of Family Physician_____**Phone** _____

Dentist/Orthodontist_____**Phone** _____

Do you carry medical/hospital insurance? Yes _____ No _____
If so, indicate: Carrier_____Policy or group #_____
IDPA Medical Card # _____

Does parent or guardian want to be notified in the event of any medical treatment the camper may require?
(Circle One) Yes No Contact Number (_____) _____

This box must be completed for Attendance

This health history is correct as 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, and necessary transportation for me/or my child. I hereby give permission to the physician selected by camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp.

Signature of parent, guardian, or adult campers/staff person

Signature:_____Date _____

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

Signature of Minor:_____Date _____

To ensure placement at camp, please return application and medical forms early!

Return to:

Camp Little Giant Registrar
Touch of Nature Environmental Center
SIUC Mailcode 6888
Carbondale, Illinois 62901
(618) 453-3950
(618) 453-1188 Fax

PHYSICIAN EXAM OF CAMPER/STAFF

To be completed by licensed physician, Nurse Practioner or P.A.

Section II: Medical Examination

1. Camper/Staff Name_____Date of Exam _____

2. Height_____Weight_____Blood Pressure_____Temperature_____Pulse_____Respiration_____

Skin Condition (bruises, cuts, scrapes, soars, etc.)

_____

_____

Glasses/Contacts: Yes___No___ Hearing Aids: Left_____Right _____

_____

IMMUNIZATION HISTORY

Please record the date (month and year) of basic immunizations and most recent booster doses.

Mandatory

Tuberculin test given _____ Result _____

TB Test must be within One (1) Year of start date of Camp Session

Tetanus vaccine given _____

Tetanus (within 10 yrs.)

Vaccines	Year of Basic Immunization	Year of Last Booster
Diptheria		
Pertussiss (Whooping Cough) DPT		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola		
Mumps		
Rubella (German measles, 3-day measles)		
Haemophilus influenza b (HIB)		
Other _____		

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

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

_____

_____

Current Treatment: _____

_____

4. Does Camper/Staff have seizures? Yes _____ No _____ Diabetes? Yes _____ No _____

5. Medication to be administered at Camp. Please submit on separate sheet if needed or attach MAR. (please print)

Name	Dosage and Time to be administered

6. Any treatment to be continued at Camp? _____

_____

7. Any medically prescribed meal plan or dietary restrictions? _____

_____

8. Any allergies (food, drugs, plants, insects, etc.)? _____

I have examined the above camp applicant. In my opinion, the applicant **MAY or SHOULD NOT** participate in an active camp program.
(CIRCLE ONE)

Licensed Physician's Signature _____

Address _____

Telephone (_____) _____

Date of form completed_____by: _____

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SIUC Mailcode 6888
Carbondale, Illinois 62901
(618) 453-1121 (618) 453-1188 Fax