

# 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	
<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart Defect Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> German measles	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Food
<input type="checkbox"/> Hypertension		<input type="checkbox"/> Mumps	<input type="checkbox"/> Other Drugs	
<input type="checkbox"/> Bleeding/Clotting Disorders		<input type="checkbox"/> Measles	<input type="checkbox"/> Insect Stings	
<input type="checkbox"/> Psychiatric Treatment		<input type="checkbox"/> Other	<input type="checkbox"/> Ivy Poisoning, etc.	
<input type="checkbox"/> Other			<input type="checkbox"/> 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? (Circle One) 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? (Circle One) 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? (Circle One) 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

Witness: \_\_\_\_\_ 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) 453-1121 ext.231  
(618) 453-1188 Fax

**PHYSICIAN EXAM OF CAMPER/STAFF**  
**To be completed by licensed physician, Nurse Practitioner 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.)**

<b>Vaccines</b>	<b>Year of Basic Immunization</b>	<b>Year of Last Booster</b>
Diphtheria	_____	_____
Pertussis (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? (Circle One) Yes No Diabetes? (Circle One) 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: \_\_\_\_\_

**To ensure placement at camp, please return application and medical forms 2 weeks in advance to:**

**Camp Little Giant Registrar  
Touch of Nature Environmental Center  
SIUC Mailcode 6888  
Carbondale, Illinois 62901  
(618) 453-1121 (618) 453-1188 Fax**