Male **Female**

Camper's
Last Name_____ First Name_____

Office Use Only
Tribe_____

HEALTH HISTORY & EXAMINATION FORM

LIGONIER CAMP & CONFERENCE CENTER

- Do not mail ahead. Please bring to camp on incoming day.
- A physical examination is required each year and must be completed by a parent/guardian with up-to-date information.
- Physician's signature is required.

Classic Summer Camp Session # ____ Little Ligs Session # ____ Next Level Session # ____

Camper's Name_____ Birth Date _____/_____/_____

Camper's Social Security Number_____

Parent/Guardian _____ Home Phone (____)_____

Home Address _____ Cell Phone (____)_____

City _____ State _____ Zip Code _____ Work Phone (____)_____

Employer _____ For whom should I ask at work?_____

Other Contact _____ Contact Phone (____)_____

Please list any known allergies including insect sting, drug, and food allergies, as well as reaction. If none, please mark N/A.

ALLERGIES: **REACTION:**

HEALTH HISTORY: *Please include date/description if applicable.*

Chronic illness or medical condition: _____

Surgeries and/or serious injuries: _____

Dietary restrictions: _____

Activities to be limited by physician's advice: _____

Any further information regarding your camper's medical history:

Check the box if your camper has been diagnosed with any of the following:

- □ Asthma
- □ ADHD
- □ Bleeding Disorder
- □ Chicken Pox
- □ Depression
- □ Diabetes
- □ Frequent Ear Infections
- □ Hay Fever
- □ Hearing Loss
- □ Hypertension
- □ Mononucleosis
- □ Measles
- □ Mumps
- □ Seasonal Allergies
- □ Seizures
- □ Severe Poison Ivy Reaction
- □ Wears glasses/ contacts
- □ Recent Infection
- □ Other

Female :
- □ Has menstruation
- □ Has difficulties with menstruation

IMPORTANT: *The box below must be completed and signed by parent/guardian to ensure camper's attendance.*

This health history is correct, so far as I know, and the camper described above has permission to engage in all prescribed camp activities, except as noted.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to administer prescription medications as prescribed by physician(s) and over-the-counter medications as directed by the parent(s) and camp protocol, to order X-rays, routine tests, treatment, and necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This form may be photocopied for trips out of camp.

Signature of Parent/Guardian _____ Date _____

Witness _____ Date _____

Male **Female**

Camper's
Last Name_____ First Name_____ Office Use Only Tribe_____

INSURANCE INFORMATION: *Please complete the information below and attach a photocopy (front & back) of your insurance card.*

Insurance Company_____ Policy # _____

Name of Insured _____ Group # _____

Policy Holder's birth date _____ Company Phone Number _____

PRESCRIPTION INFORMATION: (If different than above)

Insurance Company _____ Policy # _____

Co-payment _____

IMMUNIZATION HISTORY: *Required immunizations must be determined by your local primary care physician before coming to camp. Please record the month and year of basic immunizations and most recent booster doses.* ***You may choose to attach a copy of your camper's up-to-date immunization record.***

Vaccines	Month / Year of Basic Immunizations
Diphtheria, Pertussis,Tetanus (DPT) *	
Tetanus, Diphtheria (TD) *	
Tetanus *	
Oral Polio (Sabin) TOPV or Injectable Polio (Salk), IPV	
Measles, Mumps, Rubella (MMR)	

Vaccines	Month / Year of Basic Immunizations
Tuberculin Test (most recent)	
Haemophilus influenza b (HIB)	
Hepatitis B	
Chicken Pox Vaccine	
Other	

***Tetanus must be within 10 years.**

TO BE COMPLETED BY LICENSED PHYSICIAN OR NURSE PRACTITIONER:

Date of last physical examination (within 1 year) _____ Height _____ Weight _____

Explanation of any medical conditions/surgeries/injuries: _____

_____

Has this applicant had any reports of loss of consciousness, seizures, or concussion? If yes, explain: _____

_____

Limitations or restrictions to camp activities: _____

_____

Please list any medications/treatments/inhalers to be administered during camp:

Medication/ T(x)	Dosage, Time, Route

Medication/ T(x)	Dosage, Time, Route

Any allergies to food, drugs, plants, insects: _____

Any special considerations with medications: _____

Any diet restrictions or diet specifications: _____

Additional health information: _____

THIS BOX MUST INCLUDE THE SIGNATURE OF A LICENSED PHYSICIAN OR CERTIFIED NURSE PRACTITIONER.

I have examined the above camp applicant within one year and in my opinion, this camper's health is stable enough to participate in an active camp program.

Please Print or Stamp Physician's Name:_____

Licensed Physician's Signature: _____ Phone (____) _____

Date of Form Completion: _____ Form Completed by* _____

Initial if completed by nurse or physician's assistant.