



Good Heart, Good Times, Good Friends!

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DIRECTIONS FOR MEDICAL FORMS

The following medical forms are to be filled out by all staff! Please read the following directions carefully! **Please print or type information!** All forms received by Camp Bon Coeur will be checked for completeness. If any information is missing, the form(s) will be returned to you.

PAGES 1-2- HEALTH AND PERSONAL HISTORY DATA. This form must be completed by the legal parent/guardian of applicants or staff members who are under the age of 18. Staff members who are 18 years of age or older must complete this form.

PAGES 3-4 MEDICAL EXAMINATION FORM. This form is to be completed by a licensed physician or nurse practitioner **within six (6) months** prior to encampment. It should be filled out at the time of the examination.

CAMP BON COEUR - HEALTH AND PERSONAL HISTORY DATA

This Health and Personal History Data Form should be completed by the legal parent/guardian of minors or by staff members over 18 years of age. Please print or type only.

Applicant's Last Name	First	Middle	Nickname	Date of Birth	Age	Grade
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Address	Apt.#	City	State	Zip	Home Phone
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Applicants T Shirt Size _____

PLEASE INDICATE THE LEGAL PARENT(S) OR GUARDIAN WITH AN * IN FRONT OF THE NAME

Mother's Name	Home Phone
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Mother's Work Place	Hours/Days of Work	Work Phone
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Father's Name	Home Phone
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Father's Work Place	Hours/Days of Work	Work Phone
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Name of Person to Contact in Case of EMERGENCY / Relation	AM/PM	EMERGENCY PHONE
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Pediatric Cardiologist	Phone	Family Physician	Phone
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Dentist	Phone	Ophthalmologist	Phone
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PLEASE GIVE THE DATE THE APPLICANT LAST EXPERIENCED THE PROBLEM(S) LISTED BELOW:

<u>DATE</u>	<u>PROBLEM</u>	<u>DATE</u>	<u>PROBLEM</u>
_____	Asthma	_____	Chicken Pox
_____	Bleeding/Clotting Disorder	_____	Mumps, Measles or Rubella
_____	Diabetes	_____	Mononucleosis
_____	Hypertension	_____	Ear/Sinus Infections
_____	Endocarditis	_____	Respiratory Infections
_____	Strep Throat	_____	Bowel/Bladder Problems
_____	Rheumatic Fever	_____	Stroke/Paralysis
_____	Fainting Episodes	_____	Orthopedic Problems
_____	Seizure Disorder	_____	Chronic/Recurrent Illnesses

Please explain: _____

Yes No Is the applicant immunosuppressed or immunocompromised? Please explain

CAMP BON COEUR-HEALTH AND HISTORY DATA

Yes No Has the applicant been under the care of or counseled by a school counselor, social worker, psychiatrist or psychologist at any time? Please explain:

Yes No Is the applicant on medication to control behavior? Please list:

Yes No Does the applicant have any special dietary needs? Please explain:

Yes No Does the applicant see a mental health professional? Please explain:

Yes No Does the applicant have a problem with bed wetting? Please explain:

Yes No Do you have family medical/hospital insurance, CHAMPUS or Medicare/Medicaid?

INSURANCE PROVIDER NAME: _____

POLICY/GROUP NO.: _____

I have, to the best of my ability, accurately provided the information above.

Signature of Legal Parent/Guardian (If staff is under 18)	Date	Driver's License No. / State
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Signature of staff over 18	Date	Driver's License No./State
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Please attach a copy (front and back) of the applicant's insurance or Medicaid card.

CAMP BON COEUR - MEDICAL EXAMINATION FORM

This Medical Examination Form is to be completed by a licensed physician or nurse practitioner at the time of the examination, which must be within six (6) months prior to encampment. **Please print or type only. Please be sure to include the patient's immunization information.**

Name _____ Sex _____ Date of Birth _____ Age _____ Height (cm) _____ Weight (kg) _____

Past Medical History:

Chronic/recurrent illnesses: _____

Allergies:	<u>Type of Reaction:</u>	<u>Immunizations:</u>	<u>Date of Last Booster:</u>
___ Medications (list by name)	_____	DPT	_____
_____	_____	Td	_____
_____	_____	Tetanus	_____
___ Foods (list by name)	_____	Polio	_____
_____	_____	MMR	_____
___ Hay Fever/Pollens	_____	Hepatitis B	_____
___ Insect Stings	_____	Other_____	_____
___ Other (please list)	_____		
_____	_____		

Last Tuberculin test:
Result:_____ Date:_____

(TB test must be given to staff annually)

Physical Exam:

VS: Temp _____ Pulse _____ Resp _____ BP _____

Gen: _____

Head: _____

Eyes: _____

Ears*: _____

Nose: _____

Throat: _____

Resp: _____

CV: _____

GI/GU: _____

MS: _____

Neuro: _____

Development: (if delayed, be specific) _____

*If applicant has P.E. tubes in place, is it OK for him/her to go underwater? ___ Yes ___ No

CAMP BON COEUR – MEDICAL EXAMINATION FORM

Please list below all medications the applicant takes regularly or prn:

MEDICATION DOSE ROUTE FREQUENCY/PREFERRED TIMES REASON FOR TAKING

I have, to the best of my ability, provided the information on this medical examination form accurately.

_____ Please print or stamp office address here:

MD/NP's Signature

Date

Phone: _____