

**WEB HEALTH FORM: DUE ONE MONTH BEFORE CAMP OPENING**

**CAMP MYSTIC  
HEALTH HISTORY AND EXAMINATION FORM  
FOR CHILDREN, YOUTH AND ADULTS**

**RETURN TO  
CAMP MYSTIC  
2689 HIGHWAY 39  
HUNT, TX 78024-3412  
Office: 830-238-4660  
Fax: 830-238-4799**

**THIS INFORMATION IS TO BE FILLED OUT BY A PARENT OR ADULT CAMPER, EXCEPT THE MEDICAL EXAM, WHICH IS TO BE FILLED OUT BY A LICENSED PHYSICIAN.**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age at camp \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_  
Home address \_\_\_\_\_ Camper's Social Security # \_\_\_\_\_  
Street Address City State Zip  
 Please check if home address is new  
Father's work Phone \_\_\_\_\_ Mother's work phone \_\_\_\_\_  
Father's cell Phone \_\_\_\_\_ Mother's cell phone \_\_\_\_\_

If not available in an emergency, notify:

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone \_\_\_\_\_ Address \_\_\_\_\_  
Street Address City State Zip  
OR  
2. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone \_\_\_\_\_ Address \_\_\_\_\_  
Street Address City State Zip

**Insurance Information**

Is the patient covered by family medical/hospital insurance? \_\_\_\_ Yes \_\_\_\_ No Health Insurance Company \_\_\_\_\_  
Insurance Co. Phone # \_\_\_\_\_ Insurance Co. Address \_\_\_\_\_  
Name of insured \_\_\_\_\_ Policy Number \_\_\_\_\_

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ PARENT'S AUTHORIZATION ★ ★ ★ ★ ★ ★ ★ ★ ★ ★  
This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the examining physician. If medical treatment is necessary, I hereby give my permission to the camp to secure proper medical treatment, which may include, but not be limited to, hospitalization, surgery, ordering of injection, or anesthesia, and to receive any information concerning any treatment for my child named above. I give the camp permission to have any and all medical records and/or information concerning my child while attending camp.  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE FILLED OUT BY PARENTS:**

**Health History**

The following information must be filled in by the parent or adult camper/staff member. The information is given to provide camp health care personnel with the background to administer appropriate care.

**Allergies** List all known

Medication allergies	Describe reaction and management of reaction
_____	_____
_____	_____
_____	_____

Food allergies

\_\_\_\_\_

Other allergies – include insect stings, hay, fever, asthma, animal dander, etc.

\_\_\_\_\_

**Immunization History**

Which of the following has the participant had?

	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
_____ DTP.....	_____	_____	_____	_____	_____	_____
_____ TD.....	_____	_____	_____	_____	_____	_____
_____ Tetanus.....	_____	_____	_____	_____	_____	_____
_____ Polio.....	_____	_____	_____	_____	_____	_____
_____ MMR.....	_____	_____	_____	_____	_____	_____
_____ Haemophilus influenza B.....	_____	_____	_____	_____	_____	_____
_____ Hepatitis B.....	_____	_____	_____	_____	_____	_____
_____ Varicella (chicken pox).....	_____	_____	_____	_____	_____	_____
_____ BCG.....	_____	_____	_____	_____	_____	_____

TB Mantoux Test  
Date of Test \_\_\_\_\_  
Result \_\_\_\_ Pos \_\_\_\_ Neg

Camper's Name  
Term  
Cabin  
Year

**Medications being taken**

Please list ALL medications (including over-the-counter drugs) taken routinely. Camper should bring medication to last the entire term. The medication should be brought to camp in its original packaging which identifies the name of the patient, prescribing physician (if prescription drug), the name of the medication, the dosage, and the frequency of administration. Please **do not** take medication out of original packaging and put in ziplock baggies. Please mark all medication clearly with your daughter's name and cabin. If your child will need a prescription refill during camp, please have your doctor write one out and give it to the nurses.

\_\_\_\_\_ This person takes NO medication on a routine basis

\_\_\_\_\_ This person takes medication as follows:

Med # 1 \_\_\_\_\_ Dosage \_\_\_\_\_ Special times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med # 1 \_\_\_\_\_ Dosage \_\_\_\_\_ Special times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med # 1 \_\_\_\_\_ Dosage \_\_\_\_\_ Special times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Attach additional pages for more medications.

Please list any medications taken during the school year that participate does/may not take during summer \_\_\_\_\_

If your daughter is being treated for ADD or ADHD during the school year, please keep her on her medication at camp because of our structured activities.

**General Questions** (Explain "yes" answers below)

Has/does the participant:	YES	NO		YES	NO
1. Had any recent injury, illness or infectious disease?.....	_____	_____	15. Ever been diagnosed with a heart murmur?.....	_____	_____
2. Have a chronic or recurring illness/condition?.....	_____	_____	16. Ever had back problems?.....	_____	_____
3. Ever been hospitalized?.....	_____	_____	17. Ever had problems with joints (i.e. knees, ankles)?.....	_____	_____
4. Ever had surgery?.....	_____	_____	18. Have an orthodontic appliance being brought to camp?.....	_____	_____
5. Have frequent headaches?.....	_____	_____	19. Have skin problems (i.e. itching, rashes)?.....	_____	_____
6. Ever had a head injury?.....	_____	_____	20. Have diabetes?.....	_____	_____
7. Ever been knocked unconscious?.....	_____	_____	21. Have asthma?.....	_____	_____
8. Wear glasses or contacts?.....	_____	_____	22. Had mononucleosis in the past 12 months?.....	_____	_____
9. Ever had frequent ear infections?.....	_____	_____	23. Had problems with diarrhea or constipation?.....	_____	_____
10. Ever passed out during or after exercise?.....	_____	_____	24. Have problems with sleepwalking?.....	_____	_____
11. Ever been dizzy during or after exercise?.....	_____	_____	25. Have a history of bedwetting?.....	_____	_____
12. Ever had seizures?.....	_____	_____	Ever had emotional difficulties for which professional help was sought? (your answer will remain confidential).....	_____	_____
13. Ever had chest pain during or after exercise?.....	_____	_____			
14. Ever had high blood pressure?.....	_____	_____			

For girls and women:

Has this person menstruated? \_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_

If so, is her menstrual history normal? \_\_\_\_\_

**Please explain any "yes" answers, noting the question number.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Use this space to provide any additional information about the participant's physical health about which the camp should be aware.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please explain any specific activities to be restricted** \_\_\_\_\_

\_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**Camper Name** \_\_\_\_\_

**TO BE FILLED OUT BY LICENSED PHYSICIAN:**

**HEALTH CARE RECOMMENDATIONS BY LICENSED PHYSICIAN**

I have examined the above named camp participant. Date of last examination \_\_\_\_\_

BH \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

In my opinion, the above applicant \_\_\_\_\_ is \_\_\_\_\_ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

\_\_\_\_\_  
\_\_\_\_\_

Current treatment at the time of this report includes:

\_\_\_\_\_  
\_\_\_\_\_

**Recommendations and restrictions at camp**

Treatment to be continued at camp:

\_\_\_\_\_  
\_\_\_\_\_

Medication to be administered at camp (name, dosage, frequency):

\_\_\_\_\_  
\_\_\_\_\_

Known allergies:

\_\_\_\_\_  
\_\_\_\_\_

Description of any limitation or restriction on camp activities:

\_\_\_\_\_  
\_\_\_\_\_

Additional information for health care staff at the camp:

\_\_\_\_\_  
\_\_\_\_\_

**Signature of Licensed Physician** \_\_\_\_\_

Print Address \_\_\_\_\_

Phone \_\_\_\_\_