

2009 MONMOUTH ALL-SPORTS CAMP HEALTH FORM

Physician verification NOT required

SIGNED HEALTH FORM MUST BE COMPLETED AND RETURNED WITH APPLICATION TO:

Monmouth All-Sports Camp, 700 East Broadway, Monmouth, IL 61462 Fax: 309/457-2358 Phone: 309/457-2345

Monmouth All-Sports Camp health care is provided by a staff of registered nurses and athletic trainers. Any condition requiring intervention/management of a physician cannot be overseen by our staff. This would include uncontrolled and newly diagnosed diabetes, severe asthma, uncontrolled seizure disorder, severe heart conditions, and severe allergic reactions. These need to be conveyed to and approved by the health staff prior to camp. Failure to comply may lead to the camper's dismissal.

Check the session camper is attending: ___ 1st ___ 2nd ___ 3rd ___ 4th ___ Overnight ___ Day Camper

Camper Name _____ Birth Date _____ Age _____ Sex _____

Address _____

Home Phone (_____) _____ Cell Phone (_____) _____

Mother's Name _____ Work Phone (_____) _____

Father's Name _____ Work Phone (_____) _____

Please list two emergency contacts, other than those listed above. Parents will ALWAYS be tried first.

Name/Relation _____ / _____ Phone (_____) _____

Name/Relation _____ / _____ Phone (_____) _____

HEALTH HISTORY (check all that apply)

<p>Chronic or Recurring Illness</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bleeding Disorders</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Ear Infections</p> <p><input type="checkbox"/> Heart defect/disease</p> <p><input type="checkbox"/> Kidney disease</p> <p><input type="checkbox"/> Musculoskeletal disorders</p> <p><input type="checkbox"/> Seizures/Epilepsy</p> <p><input type="checkbox"/> Sinusitis</p> <p><input type="checkbox"/> Other (Specify) _____</p> <hr/> <p>Emotional or Social Challenges</p> <p><input type="checkbox"/> ADD/ADHD</p> <p><input type="checkbox"/> OCD</p> <p><input type="checkbox"/> Eating Disorders</p> <p><input type="checkbox"/> Bipolar Disorder</p> <p><input type="checkbox"/> Other (Specify) _____</p>	<p>Other Health Conditions</p> <p><input type="checkbox"/> Bedwetting</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Frequent headaches</p> <p><input type="checkbox"/> Frequent sore throats</p> <p><input type="checkbox"/> Frequent stomach aches</p> <p><input type="checkbox"/> Hearing impairment</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Sleep Walking</p> <p><input type="checkbox"/> Wears glasses</p> <p><input type="checkbox"/> Wears orthodontic devices</p> <p><input type="checkbox"/> Other (Specify) _____</p> <hr/> <hr/> <hr/> <hr/>	<p>In the last year has camper had:</p> <p><input type="checkbox"/> Any injury/illness requiring medical attention within the last 6 months</p> <p><input type="checkbox"/> A surgical operation or fracture</p> <p>Current issues:</p> <p><input type="checkbox"/> Receiving psychological/psychiatric counseling</p> <p><input type="checkbox"/> Under a physician's care</p> <p><input type="checkbox"/> Restricted from physical activity</p> <p><input type="checkbox"/> Taking prescription medication (complete reverse side)</p> <p><input type="checkbox"/> Taking over the counter medication (complete reverse side)</p> <p>Please explain any items checked above. Give dates and include any information that would be helpful to camp staff in relations to these health concerns. Add an additional sheet if needed:</p> <hr/> <hr/> <p><i>If camper receives special educational services, a copy of the current IEP is required.</i></p>
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ALLERGIES/REACTION MANAGEMENT - List known medications, food, insect stings, hay fever, etc.	RESTRICTED ACTIVITIES - List activities not allowed to participate in due to medical reasons.
Epi-pen: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Health Insurance Co _____ Policy No. _____ Group No. _____

Policy Holder _____ (Employer) _____

Policy Holder Date of Birth _____ Policy Holder Zip Code _____

Health Insurance Co. Phone No. _____ Policy Plan _____

Health Insurance Co. Address _____

(PLEASE COMPLETE REVERSE SIDE)

Camper Name _____ Weight _____ Height _____

- All medications, both prescription and over-the-counter, must be sent in their ORIGINAL CONTAINERS. (Do not place medication in pill boxes or medication reminder boxes).
- Please do not mix siblings' medications
- **ALL PRESCRIPTION MEDICATIONS, including psychiatric and ADD/ADHD medications, must be dispensed per health staff nurses.**

The following medications are supplied by the health staff – **DO NOT** send with camper.

Please indicate if you give permission for the Monmouth All-Sports Camp health staff to administer and dispense to camper:

Tylenol / Acetaminophen	_____yes	_____no
Ibuprofen / Advil / Motrin	_____yes	_____no
Benadryl (allergy/allergic reaction)	_____yes	_____no
Tums (stomach ache)	_____yes	_____no

Note: Campers DO NOT have access to dorm rooms between 7:00 a.m. and 9:00 p.m.

MEDICATIONS

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep medications in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

- Camper takes **NO** medications on a routine basis.
 Camper takes medications as indicated below:

Medicine #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking medication _____

Medicine #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking medication _____

Medicine #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking medication _____

Medicine #4 _____ Dosage _____ Specific times taken each day _____

Reason for taking medication _____

Please identify any medications taken during the school year that camper does/may not take during the summer: _____

****Attach additional pages for more medications****

Direct all medical questions to the Camp Office: 309/457-2345

Parent/Guardian Authorization: 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 by me.

Parent/Guardian Signature _____ Date _____

Visit our website at www.monm.edu/allsportscamp.htm Email us: sportscamp@monm.edu