

HEADFIRST CAMPER HEALTH HISTORY RECORD 2010

This Health History Record must be completed and returned to the Headfirst office.

If this camper has had a physical exam within 2 years from the start of camp, a new exam is not required. Please complete Section A of this form and attach a copy of your child's most recent physical examination (a copy may be obtained from your physician or your child's school nurse). If your child has NOT had a physical exam within 2 years of the start of camp, please make an appointment with your child's physician to conduct an examination and complete Section B of this form. Whether

or not your child requires a new exam, your child's physician must sign Section B of this form.

This health form must be completed and returned to Headfirst Summer Camps on or before June 1. If you are enrolling after this date, please send in your forms immediately after enrolling.

A few important notes to bear in mind: 1) One form per child please. 2) If this camper has attended a Headfirst Camp in the past calendar year, you do not have to send in this form.

SECTION A: TO BE COMPLETED BY CAMPER'S PARENT/GUARDIAN SIDE 1

Last Name: _____ First Name: _____ M F

Date of Birth: _____ / _____ / _____ Home Phone: () _____

Address: _____
STREET CITY ZIP

Camper's School Name: _____ Camper's School (City and State) _____ / _____

Mother's Name: _____ Bus. Phone () _____ Mobile: () _____

Father's Name: _____ Bus. Phone: () _____ Mobile: () _____

Emergency Contact: _____ Relationship: _____

Home Phone: () _____ Bus. Phone: () _____ Mobile: () _____

■ Does camper take any prescription medicines? Y N If yes, please list below:

Medicine	Dosage(s):	Needed for:
_____	_____	_____
_____	_____	_____
_____	_____	_____

■ Will camper need to take medicines while at camp? Y N If yes, please indicate which medicine(s)

■ Does this camper have allergies? Y N If yes, please indicate:

- Peanut Tree Nut Pollen, grass, weeds, etc Bee sting Drugs _____ Foods _____
 Other: _____

Explanation of allergies and list of symptoms to watch for: _____

■ Is an Epi Pen used for the above allergy: Y N

■ Does this camper have any reoccurring or chronic illness(es)? Y N If yes, please list

- Asthma Cardiac Conditions Diabetes Type I Diabetes Type II Seizures Other: _____

Explain in detail: _____

Indicate here any additional health information that Headfirst should be aware of: _____

*Note: Headfirst requires that the camper's physician complete the Medical Consent, see side 2, before we can administer medicine to this camper.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

HEADFIRST OFFICE USE ONLY: Complete Missing Parent/guardian Signature Date Of Last Exam
 Physician's Signature & Date Doctors's Order For Medication Administration Other _____

Camper Name: _____

Home Phone: () _____

SECTION B: TO BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN THAT HAS CONDUCTED AN EXAMINATION OF THIS CAMPER

Date of physical exam ____ / ____ / ____	Height _____	Weight _____	Date of last Tetanus shot ____ / ____ / ____	Is this camper up-to-date on all required immunizations <input type="checkbox"/> Yes <input type="checkbox"/> No

■ Provide information about this camper's behavior, emotional and physical health. Have there been any hospitalizations, injuries or operations? Does camper have any limitations or restrictions Headfirst should be aware of?

■ If camper has Asthma, please rate: Mild Intermittent Mild Persistent Moderate Severe
Please describe this condition. What are the symptoms and what treatment is needed?

■ Does camper have a cardiac condition? Y N If yes, provide a list of limitations and/or restrictions:

■ Provide medical instruction for relevant routine care and emergencies. Include any prescription over-the-counter medicines that camper may require while at camp:

MEDICAL CONSENT SECTION: If camper will be taking medications while at camp, this section MUST BE COMPLETED, (including any medications prescribed by a physician, both non-prescription or over-the-counter). **PLEASE NOTE: Headfirst strives to provide the highest quality care for all campers with food allergies. Headfirst Summer Camps follows the guidelines expressed by the American Academy of Allergy, Asthma and Immunology. Recommendations are that if a potentially life-threatening reaction to food occurs, injectable epinephrine (Epi Pen) is used as first line of treatment. Oral antihistamines (i.e. Benadryl) will only be used as an additional therapy.**

1. Medication: _____ Dosage: _____ Frequency: _____
Reason for medication: _____

Doctor's orders: _____

2. Medication: _____ Dosage: _____ Frequency: _____
Reason for medication: _____

Doctor's orders: _____

This camper is in good health and may engage in all camp activities: Examining Physician's signature: _____ Date: ____ / ____ / ____ Physician Telephone: () _____	Physician Name and Address (Please print)

HEADFIRST SUMMER CAMP

Please return this form to: Headfirst Camps • 2440 Wisconsin Ave., NW • Suite 201 • Washington, DC 20007 Phone: (202)625-1921 Fax: (202) 249-1047

HEADFIRST SUMMER CAMP

CARPOOL PICK-UP AUTHORIZATION

■ Please list all authorized persons to pick up campers:

■ Please list all persons restricted from visitation or pick up:

PERMISSION FOR EXTERNAL APPLICATION / OVER-THE-COUNTER SKIN PRODUCTS

■ My child Has Has NOT any allergic/unusual reaction to sun block or insect repellent, if so, please describe:

■ If necessary, I grant permission for camp staff to apply or provide sun block/insect repellent: Yes No

Records of administrations for insect repellent will be recorded on a Medication Administration Sheet.
(This form may be obtained at each camp location)

Parent/Guardian: This permission statement is correct and complete.

Signature: _____ **Date:** ____/____/____

Instructions:

1. You only need to complete one form per summer regardless of how often you enroll in a Headfirst Camp.
2. Please fax or mail this paperwork to Headfirst Camps NO LATER THAN June 1. If you enroll in a camp program after June 1, please mail or fax this form to the office immediately.

**Headfirst Camps
Attn: Medical Forms
2440 Wisconsin Ave. NW; Suite 201
Washington, DC 20007**

Fax: (202) 249-1047