To Be Completed and Signed by Parent or Guardian

CAMP HONOR - CAMPER HEALTH HISTORY FORM 2024

Name _____ DOB _____
Last First Middle Initial

Home address _____
Street address City State Zip

Guardian Cell Phone _____ Home Phone _____ Gender: □ Male □ Female

EMERGENCY Contact _____ Relationship _____

Cell Phone _____ Work Phone _____ Home Phone _____

If above contact person not available in an emergency, notify:

Name _____ Relationship _____

Cell Phone _____ Work Phone _____ Home Phone_____

Insurance Information

Are you covered by medical insurance? □ Yes □ No If Yes, complete the following:

Insurance Company Name _____Phone #_____

Name of Policy holder _____ Relationship to Participant _____

Policy # _____ Group #/ Plan #_____ Physician Name _____

Medical Release

In case of medical and/or surgical emergency, I authorize Camp HONOR medical staff to render or to arrange for my child (print full name) _____ to receive any x-ray, anesthetic, medical, dental, surgical procedure, treatment, and hospital care which is deemed advisable by and is to be rendered under the supervision of any physician, dentist or surgeon licensed in Arizona.

Parent/Guardian Signature _____ Date _____

—Complete This Box for Campers with Bleeding Disorders—

Type of Bleeding Disorder: □VIII □IX □VWD □Other _____ Level/Severity _____

Current Transfusion Product _____

Life-threatening Bleeds _____Units Major Bleeds _____Units Minor Bleeds _____Units

Home Infusion? ____Yes ____No Describe any Target Joints _____

Inhibitor? _No _Yes – If yes, Last Titer and date _____ Immune Tolerance ___No ___Yes Are you on Prophylaxis? _No _Yes – If Yes Dose and Schedule _____

Do you have a Central Line? ____No ____Yes – If Yes What Type? _____

Hepatitis B Antigen ____Pos ____Neg Hepatitis B Surface Antibody ____Pos ___Neg Hepatitis C ____Pos ____Neg

Name _____ DOB
Last First Middle Initial

The following information must be completed by the parent/guardian. The intent of this information is to provide camp medical staff background information to provide appropriate care and be aware of your needs.

ALLERGIES List all known Describe reaction and previous management

Medication allergies (list)

Food allergies or Restrictions (list)

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

MEDICAL CONDITIONS

HIV____ Heart Disease ____ Kidney Disease ____ Asthma ____ Seizure Disorder ____ Diabetes ____ High blood Pressure ____

Please Explain Any Significant Medical History _____

MEDICATIONS

Please list All medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it 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.

☐ This person takes NO medications on a routine basis.

List Medications

Drug Name	Dose	Schedule	Reason for Taking

HIPPA RELEASE STATEMENT

(Medical Privacy)

I authorize the medical staff of CAMP HONOR to release my child's medical information to his/her camp counselor and their supervisors. I understand that my child's medical information is shared with these staff members so that they can provide the best care and experience for my child while at camp.

_____ _____
Signature of Parent or Guardian Date

This form is to be completed by a Licensed Health-Care Practitioner

CAMP HONOR – CAMPER MEDICAL FORM 2024

Name _____ DOB _____
Last First Middle Initial

I have examined the above participant. Date of last examination _____

Weight _____ BP _____/_____ Pulse _____

MEDICAL CONDITIONS

Heart Disease ____ Kidney Disease ____ Asthma ____ Seizures ____ Hemophilia or VWD ____ HIV ____ Diabetes ____

Other:_____

Allergies: _____

Any recent significant illnesses, injuries, infections, or hospitalizations:_____

_____

—PHYSICIANS Complete This Box for Campers with Bleeding Disorders—

Type of Bleeding Disorder: □VIII □IX □VWD □Other _____ Level/Severity _____

Current Transfusion Product _____

Life-threatening Bleeds _____Units Major Bleeds _____Units Minor Bleeds _____Units

Home Infusion? ____Yes ____No Describe any Target Joints _____

Inhibitor? ____No ____Yes – If yes, Last Titer and date _____ Immune Tolerance ____No ____Yes

Prophylaxis? ____No ____Yes – If Yes Dose and Schedule _____

Central Line? ____No ____Yes – If Yes What Type? _____

Hepatitis B Antigen ____Pos ____Neg Hepatitis B Surface Antibody ____Pos ___Neg Hepatitis C ____Pos ____Neg

PHYSICAL EXAM

GENERAL	NORMAL	ABNORMAL	EXPLAIN ABNORMALITIES
Head & Neck	_____	_____	_____
Eyes & Ears	_____	_____	_____
Nose & Throat	_____	_____	_____
Chest	_____	_____	_____
Heart	_____	_____	_____
Abdomen	_____	_____	_____
Skin	_____	_____	_____
Lymphatic	_____	_____	_____
Neurological	_____	_____	_____
Joints/Muscles	_____	_____	_____

Name _____ DOB _____
Last First Middle Initial

Assessment and/or any other significant medical history/psychosocial history:

_____

_____

_____

Limitations

Activity restrictions _____

Diet restrictions _____

Immunizations Please attach immunization record

MEDICATIONS

Please list All medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it 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.

□ This person takes NO medications on a routine basis.

List Medications

Drug Name	Dose	Schedule	Reason for Taking

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

Signature of Provider _____ **Date**_____ **Phone** _____

Printed Name _____ **Mailing address** _____

Return to: Arizona Bleeding Disorders
826 N 5th Ave
Phoenix, AZ 85003
Fax: 602-955-1962