Mandaville Camp & Retreat Center
165 Sheldon Road Winthrop, NY 13697
Phone: (315) 328-4581; e-mail: director@campmandaville.org

Medical History Form

Session _____ Year _____

Name_____ _____/_____/_____ ❑ Male ❑ Female
Last First MI Date of Birth

Diagnosis(es)_____

_____

Address_____ Apt._____

City_____State_____Zip_____

Phone_____ Cell Phone_____

Custodial Parent/Guardian (If applicant is an independent adult, please list person to contact in event of an emergency)

Name _____ Relationship _____

Address (if different from above) _____

_____

Emergency Contacts (to be used if above contact cannot be reached in an emergency. Please list at least two.)

Name	Relationship	Phone Number(s)

Health Insurance: Is the camper covered by family medical/hospital insurance or Medicaid? ❑ Yes ❑ No
** You **MUST** attach a copy of **BOTH SIDES** of your insurance card(s) or benefit card(s) **

Name of Insurance Company	Name of Policy Holder	Policy Number	Effective Date

Treatment and Emergency Care Authorization
(must be signed by parent/guardian or adult camper)

1. I give permission to the camp to provide ongoing and routine healthcare, to administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I give permission for health center RN to obtain results of tests and x-rays. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for the individual listed above.
2. In the event I cannot be reached in an emergency, I give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the applicant.
3. I give permission for the above named individual to go swimming with adequate supervision.
   Please check one: ❑ Yes ❑ No
4. This health history is correct and complete to the best of my knowledge.

Signature of parent/guardian or adult camper_____

Health History

Please answer each of the following questions and explain all "yes" answers below or on an attached sheet.
Has/does the camper:

1. Had any injury, illness, hospitalization including any trip to the emergency room, surgery or infectious disease within the last six months? ❑ Yes ❑ No
2. Have a chronic or recurring illness/condition other than disabilities listed? ❑ Yes ❑ No
3. Ever had surgery? ❑ Yes ❑ No
4. Have frequent headaches? ❑ Yes ❑ No
5. Ever had a head injury? ❑ Yes ❑ No
6. Wear glasses or contacts? ❑ Yes ❑ No
7. Have frequent ear infections? ❑ Yes ❑ No
8. Ever passed out, experienced dizziness or chest pain during exercise? ❑ Yes ❑ No
9. Ever had high blood pressure? ❑ Yes ❑ No
10. Ever been diagnosed with a heart murmur? ❑ Yes ❑ No
11. Ever had back problems? ❑ Yes ❑ No
12. Ever have bleeding or clot disorders? ❑ Yes ❑ No
13. Ever had an allergic reaction to latex? ❑ Yes ❑ No
14. Ever had problems with joints? (i.e. knees, ankles) ❑ Yes ❑ No
15. Have an orthodontic appliance being brought to camp? ❑ Yes ❑ No
16. Have any skin problems? (i.e. itching, rash, acne) ❑ Yes ❑ No
17. Have diabetes? ❑ Yes ❑ No
18. Have asthma? ❑ Yes ❑ No
19. Had problems with diarrhea/constipation? ❑ Yes ❑ No
20. Had problems with sleepwalking? ❑ Yes ❑ No
21. If female, have an abnormal menstrual history? ❑ Yes ❑ No
22. Have a recent history of bedwetting? ❑ Yes ❑ No
23. Ever had an eating disorder? ❑ Yes ❑ No
24. Ever had emotional difficulties for which professional help was sought? ❑ Yes ❑ No

_____

_____

Allergies (Please list all known allergies, and describe reaction and management of the reaction)

Medication, Food, or other Allergy	What is the reaction and how is it managed?

Does the camper have a history of seizures (other than in infancy?) ❑ Yes ❑ No Date of last seizure _____
If yes, please give the type(s) of seizure; describe seizure activity, warning signs, duration, special precautions, etc:

_____

_____

For females: Has she menstruated? ❑ Yes ❑ No If no, has she been told about it? ❑ Yes ❑ No

Which of the following has the camper had?
❑ Measles ❑ Chickenpox ❑ German Measles ❑ Mumps ❑ Hepatitis A ❑ Hepatitis B ❑ Hepatitis C ❑ MRSA

Acknowledgment of Receipt of Privacy Notice: [ ] I have received a copy of the Notice of Privacy Practice

Parent / Guardian Signature _____ Date _____

Personal Physicians (Please list all physicians providing follow-up care or prescribing medication for the camper)

Physician's Name	Phone Number	Specialty

Immunizations

Immunization History: This is **REQUIRED** TO BE COMPLETED FOR EVERYONE ATTENDING CAMP UNDER THE AGE OF 26. If over the age of 26, the dates of the last tetanus booster is required and the meningococcal vaccine is recommended.

Vaccine:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
Meningococcal						
DTP						
TD						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
Or Rubella						
Haemophilus Influenza B						
Hepatitis B						
Varicella						
Other						

TB Mantoux Test Date of Last Test:_____ Result: ❑ Positive ❑ Negative

*You may include a copy of your child's immunization record from your Health Care Provider or School Nurse

REQUEST FOR EXEMPTION FROM IMMUNIZATIONS

If you do not get immunizations due to your personal convictions we ask that you complete this form, sign it, and return it to us so we may have it on record.

I, _____, because of _____

_____reasons do not get immunizations. I attest to the fact that at this time I am free of any communicable or contagious disease. I understand and agree to leave the camp premises immediately should any of the diseases covered by immunizations occur while I am there. I am releasing Bible Centered Ministries/Camp Mandaville from any responsibility for any impairment of health resulting because of this exemption.

_____ _____

Signature Date

_____ _____

Signature of Parent/Guardian (if above individual is under 21 years of age) Date