CAMP ENCORE/CODA

a great summer of music, sports and friends!

Winter: 55 Marmion St Apt 2 Jamaica Plain, MA 02130 Tel: 617-584-1129
Summer: 50 Encore/Coda Lane, Sweden, ME, 04040 Tel: 207-647-3947 Fax: 207-647-3259
Email: cara@encorecoda.com
www.encorecoda.com

Dear parents,

Please be sure to include a complete record of immunizations with this health form when you send it to us. Or, if you have a bonafide religious reason why you have not had your child immunized that meets the criteria outlined in the Maine state guidelines below, a statement from you to that effect.

The Maine immunization guidelines are available in detail at: https://www1.maine.gov/dhhs/mecdc/infectious-disease/immunization/family/documents/immunization-requirements-for-school-children.pdf

Many thanks,

Cara

Camp Encore/Coda, Sweden, Maine 04040

Health History and Examination Form for Campers & Staff Members

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care and securing emergency treatment if required. Attendance at camp is contingent on our receiving this form, appropriately completed by camper parent/guardian (or staff member) and licensed medical personnel.

If completed **before May 24th,** please scan and email to cara@encorecoda.com or mail to:
55 Marmion St Apt 2 Jamaica Plain, MA 02130
If completed **after May 24th,** please mail to: 50 Encore/Coda Lane, Sweden, ME 04040 or fax to 207-647-3259
you can also scan and email to cara@encorecoda.com at any time

Personal Information

Name _____ Birth date _____ Age at camp _____
Last First Middle

Dates of Camp Attendance (circle one): 1st Session 2nd Session Full Season Staccato Session Gender:

Home address _____
Street address City State Zip

Parent/Guardian 1 _____ Phone _____ Email: _____

Home address _____
Street address City State Zip

Parent/Guardian 2 _____ Phone _____ Email: _____

Address _____ Phone _____
Street address City State Zip

If not available in an emergency, notify: Name _____

Relationship _____ Phone _____ Email: _____

Address _____
Street address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? [ ] Yes [ ] No

If so, indicate carrier or plan name _____

Carrier address _____ Group # _____

Name of insured _____ Relationship to participant _____

Social security number of policy holder or insurance ID number _____

Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____

Witness _____ Date _____

I understand and agree to abide by the restrictions placed on my camp activities.

Signature of minor or adult camper/staffer _____Date _____

Health History

The following information must be filled in by the parent/ guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

_____ _____
_____ _____
_____ _____
_____ _____

Food allergies (list)

_____ _____
_____ _____
_____ _____

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

_____ _____
_____ _____
_____ _____

MEDICATIONS BEING TAKEN

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.

[ ] This person takes medications as follows:

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

Reason for taking _____

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

Reason for taking _____

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

Reason for taking _____

Attach additional pages for more medications.
Identify any medications taken during the school year that participant does/may not take during the summer:

_____

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

[ ] Does not eat red meat [ ] Does not eat pork [ ] Does not eat poultry
[ ] Does not eat seafood [ ] Does not eat eggs [ ] Does not eat dairy products
[ ] Other (describe) _____

_____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

_____

General Questions (Explain "yes" answers below.)

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infectious disease?	[ ]	[ ]
2. Have a chronic or recurring illness/condition?	[ ]	[ ]
3. Ever been hospitalized?	[ ]	[ ]
4. Ever had surgery?	[ ]	[ ]
5. Have frequent headaches?	[ ]	[ ]
6. Ever had a head injury?	[ ]	[ ]
7. Ever been knocked unconscious?	[ ]	[ ]
8. Wear glasses, contacts or protective eye wear?	[ ]	[ ]
9. Ever had frequent ear infections?	[ ]	[ ]
10. Ever passed out during or after exercise?	[ ]	[ ]
11. Ever been dizzy during or after exercise?	[ ]	[ ]
12. Ever had seizures?	[ ]	[ ]
13. Ever had chest pain during or after exercise?	[ ]	[ ]
14. Ever had high blood pressure?	[ ]	[ ]
15. Ever been diagnosed with a heart murmur?	[ ]	[ ]
16. Ever had back problems?	[ ]	[ ]
17. Ever had problems with joints (e.g., knees, ankles)?	[ ]	[ ]
18. Have an orthodontic appliance being brought to camp?	[ ]	[ ]
19. Have any skin problems (e.g., itching, rash, acne)?	[ ]	[ ]
20. Have diabetes?	[ ]	[ ]
21. Have asthma?	[ ]	[ ]
22. Had mononucleosis in the past 12 months?	[ ]	[ ]
23. Had problems with diarrhea/constipation?	[ ]	[ ]
24. Have problems with sleepwalking?	[ ]	[ ]
25. If female, have an abnormal menstrual history?	[ ]	[ ]
26. Have a history of bed-wetting?	[ ]	[ ]
27. Ever had an eating disorder?	[ ]	[ ]
28. Ever had emotional difficulties for which professional help was sought?	[ ]	[ ]

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

_____

_____

Which of the following has the participant had?

[ ] Measles
[ ] Chicken pox
[ ] German measles
[ ] Mumps
[ ] Hepatitis

TB Mantoux Test
Date of last test _____
Result: [ ] Positive [ ] Negative

Please give all dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
MMR	_____	_____				
or Measles	_____	_____				
or Mumps	_____	_____				
or Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Varicella (chicken pox)	_____	_____				
BCG	_____					

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

_____

_____

_____

_____

_____

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

and the person herein described has permission to engage in all camp activities except as noted.

Signed _____ Printed _____ Date _____

Health Care Recommendations by Licensed Medical Personnel

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

BP _____ Weight _____ Height _____

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

_____

_____

Medications to be administered at camp (name, dosage, frequency)

_____

_____

Any medically-prescribed meal plan or dietary restrictions

_____

_____

Known allergies

_____

_____

Description of any limitation or restriction on camp activities

_____

_____

Additional information for health care staff at the camp

_____

_____

Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

For camp use only

Screening Record

Date screened _____ Time _____am/pm

Meds received _____

_____

Updates/additions to health history noted [ ] Yes [ ] No [ ] None required

Current health needs identified _____

Observational notes _____

_____

Screened by _____