





# CAMP DAYBREAK

## Staff Medical Form

### Have you /Do you?

- |  | Yes                      | No                       |  | Yes                      | No                       |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Had any recent injuries, illness, or infectious disease?..... | <input type="checkbox"/> | <input type="checkbox"/> | 11. Ever had chest pains?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition?                | <input type="checkbox"/> | <input type="checkbox"/> | 12. Ever had high blood pressure?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized?.....                                  | <input type="checkbox"/> | <input type="checkbox"/> | 13. Ever been diagnosed with a heart murmur?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery?.....  | <input type="checkbox"/> | <input type="checkbox"/> | 14. Have any skin problems (e.g., itching, rash)?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches?.....                                 | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have diabetes?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury?.....                                  | <input type="checkbox"/> | <input type="checkbox"/> | 16. Have asthma?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious?.....                           | <input type="checkbox"/> | <input type="checkbox"/> | 17. Had mononucleosis in the last year?.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Ever had frequent ear infections?.....                        | <input type="checkbox"/> | <input type="checkbox"/> | 18. If female, have an abnormal menstrual history?.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever passed out?.....   | <input type="checkbox"/> | <input type="checkbox"/> | 19. Ever had emotional difficulties for which professional help was sought?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever had seizures?.....                                      | <input type="checkbox"/> | <input type="checkbox"/> | 20. Ever had problems with joints (e.g., knees, ankles)?.....                    | <input type="checkbox"/> | <input type="checkbox"/> |

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

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### Medication:

- No daily medications     Will take the following prescribed medication(s) while at camp (name, dose, frequency –describe below)

Do you feel like you will require limitations or restrictions to activities while at camp?     No     Yes

\*If you answered "yes" to the question above, please explain.

### Important – These boxes must be complete for attendance

<p>This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.</p> <p>It is my intention that Camp Daybreak be treated as acting <i>in loco parentis</i> if the person herein named is a minor.</p> <p>I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including but not limited to x-rays,</p> <p>Signature of parent or guardian or adult staffer _____</p> <p>Printed Name _____</p>	<p>routine tests and treatment, and or hospitalization. I also give permission for the camp to arrange any related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.</p> <p>In the event that I cannot be reached in an emergency, I hereby give permission to the medical professional selected by Camp Daybreak to secure and administer treatment, including hospitalization.</p> <p>Date _____</p>
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