Staple together please

2017 HEALTH FORM

Complete and Return to:

Riverview Camp for Girls
P. O. Box 299
Mentone, AL 35984
Susan and Larry Hooks, Directors
Phone: 800-882-0722 • Fax: (256) 634-3601
www.riverviewcamp.com Email: Info@riverviewcamp.com

MUST BE COMPLETED AND RETURNED BY MAY 15th
Please keep a Copy for your Records.

- Parents/Guardians complete Page 1 and Sections 1 and 2 of Page 2.
- **Physicians complete Sections 3 and 4 of Page 2.**
- Exception: Section 2 (Immunization Record) may be Completed by either Parent/Guardian or Physician

OFFICE USE ONLY:
Cabin: _____

Sessions Attending: **(please circle)** M, 1, 2, 3, 4, A, B, C, D, E, F

Camper arriving by **(please circle one):** CAR BUS PLANE

***IMPORTANT*: FRONT AND BACK COPIES OF INSURANCE CARDS (and PRESCRIPTION CARDS when applicable) ARE REQUIRED WITH THIS FORM (PLEASE MAKE SURE COPIES ARE LEGIBLE): If an attending medical facility will not file the insurance on your behalf, any related bills incurred will be mailed directly to the Parents, Guardian or Staff Member or deducted from the camper's spending account.**

Name: _____ Age: _____ Birth M/D/Y: _____ Years at Riverview: _____

Camper SS #: _____ (required by medical facilities) Sex _____ Height _____ Weight _____

Parent or Guardian: _____ Phone: (_____) _____

Home Address: _____
Street Number City State Zip Code

Sister(s) who attend Riverview: _____ Age: _____

Mother's Occupation: _____ W Phone: (_____) _____ H Phone:(_____) _____ Cell : (_____) _____

Father's Occupation: _____ W Phone: (_____) _____ H Phone:(_____) _____Cell : (_____) _____

In An Emergency, Please Notify: _____ H Phone: (_____) _____ Cell: (_____) _____

If **NOT** Available In An Emergency, Notify: _____ Phone: (_____) _____ Cell: (_____) _____

Name of Family Physician and/or Health Care Clinic: _____ Phone: (_____) _____

Name of Dentist/Orthodontist: _____ Phone: (_____) _____Name of Ophthalmologist/Optometrist: _____ Phone: (_____) _____

Date of Last Physical Examination by a Physician: _____ Please give name of Physician: _____Phone: (_____) _____

Operations or serious injuries (dates): _____

_____

Chronic or recurring illness or medical condition: _____

_____

Current medications: (complete camper medication record on opening day of camp)_____

Diet restrictions: Attach explanation of severity:_____

☐ ***Check here if there are NO known allergies***

ALLERGIES: *Explain (attach necessary information if severe)*

____ Asthma _____

____ Hay Fever_____

Ivy Poisoning _____

____ Insect Stings_____ _____

____ Severe (stop breathing)_____

____ Mild (swelling/rash) _____ _____

____ Foods/possible reaction:_____

____ Drugs/possible raction:_____

PARENT/GUARDIAN ITINERARY:

If you plan to be out of town while your child is at camp, please indicate your complete itinerary below and numbers where you can be reached. Or attach a separate sheet and note below.

Date	Place	Phone #

Camp Nurse: Initial here after review of form:_____date:_____

IMPORTANT – MUST BE COMPLETED FOR ATTENDANCE: This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed camp activities except as noted. I understand that this person will be participating in an active and sometimes strenuous activity schedule that will include one or more of the following: athletic participation and competition, horseback riding, gymnastics, dance, archery, riflery, water sports, ropes course, climbing tower, tennis, walking or hiking over rocky terrain, field games and sports, overnight camping and other general camp games and activities. I understand that the possibility of accident or injury does exist and that there is inherent risk in participation in this program. I have given / will give full and complete medical background information, and medications needed, etc. that will assist in the care of this participant. WAIVER: I hereby assume all risk of injury, illness, death and loss of or damage to person or personal property arising from participation on this property or in the programs offered. I indemnify and save harmless Riverview Camp, Inc, Nature's Classroom Atop Lookout Mountain, Inc and property owners and staff and release them from every claim, demand, liability, loss, damage, cost, charge, attorney's fee, expenses of suit, order, judgment and adjudication whatsoever incurred hereafter by Riverview Camp, Inc, Nature's Classroom and property owners and staff growing out of or related to the participation in the program and use of the facilities or use of outside medical facilities hereby furnished. I agree to use of mediation in event of any dispute or claim. I give permission to Riverview Camp for Girls to use photos or videos made at camp and any articles, poems, etc. that my child may write about camp to be used by Riverview for promotional purposes, including use of on-line social media or website.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications, including prescription drugs; to seek emergency medical treatment; order X-rays; routine tests, or treatment, and to provide or arrange necessary related transportation for me or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp, or faxed if necessary. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

_____ Date: _____
Signature of Parent/Guardian or Adult Staff

Name: _____

Address: _____

City, State, Zip: _____

Fee required and will be billed to your account if Riverview Doctor performs Wellness check.

Parent or Adult Applicant: Fill in Sections 1 and 2 BEFORE SEEING PHYSICIAN: Be sure to include any emergency information and restrictions or special care that should be observed. Especially be sure to record any injuries, illness, surgery, or significant changes in condition of applicant since last complete exam.

Section 1: Give dates and full details below for any "Yes" Answers, WHETHER CURRENT, PAST OR PRESENT. ATTACH ADDITIONAL INFORMATION SEPARATELY AS NECESSARY FOR NEEDED CARE:

	Yes	No	Year
1. Serious Illness	___	___	_____
2. Serious Injury	___	___	_____
3. Deformity	___	___	_____
4. Surgery	___	___	_____
5. Skin Glands	___	___	_____
6. Nose Sinusitis	___	___	_____
7. Heart	___	___	_____
- Murmur	___	___	_____
- Rheumatic Fever	___	___	_____
8. Chest, Lungs	___	___	_____
9. Stomach, bowels	___	___	_____
10. Appendicitis	___	___	_____
11. Kidneys or urine	___	___	_____
- Albumin	___	___	_____
- Sugar	___	___	_____
- Infection	___	___	_____
- Bed-wetting	___	___	_____
12. Menstrual prob.	___	___	_____
13. Hernia	___	___	_____
14. Back,limbs,joints	___	___	_____
15. Sleepwalking	___	___	_____
16. Nervous Cond.	___	___	_____
17. Eyes/Ears	___	___	_____

	Yes	No	Year
18. Hearing impaired	___	___	_____
19. Hypertension	___	___	_____
20. Convulsions	___	___	_____
21. Epilepsy	___	___	_____
22. Constipation	___	___	_____
23. Athlete's Foot	___	___	_____
24. Panic Attacks	___	___	_____
25. Bronchitis	___	___	_____
26. Fainting	___	___	_____
27. Depression	___	___	_____
28. Sore Throats	___	___	_____
29. Bleeding/Clotting	___	___	_____
30. Mononucleosis	___	___	_____
31. Sprains or breaks	___	___	_____
32. Chicken Pox	___	___	_____
33. Measles	___	___	_____
34. German Measles	___	___	_____
35. Mumps	___	___	_____
36. Asthma	___	___	_____
37. Tuberculosis	___	___	_____
38. Other(explain)	___	___	_____
39. Hepatitis A,B,C	___	___	_____
40. ADHD/ADD	___	___	_____

41. Are you aware of any current health problem? ___Yes ___No
42. Now under medical care or taking medications? ___Yes ___No
43. Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? ___Yes ___No

Details:(Give # & Details or attach separate sheet with info)

_____

_____

CONDITION OF: Eyes _____ Glasses _____ Contacts _____

What procedures should be taken if lost or broken at camp? _____

_____

CONDITION OF: Teeth _____ Braces _____ Retainer _____

What procedures should be taken if lost or broken at camp? _____

_____

For Girls: has this person Menstruated? _____ If not, has she been informed? _____

If so, is her menstrual history normal? _____

IMPORTANT: PLEASE notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp. URGENT FOR THE WELL-BEING OF ENTIRE CAMP.

Section 2: IMMUNIZATION HISTORY **To be completed by Parent *or* Physician's Office**

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) Tetanus or **DPT** Tetanus	1. 2. 3.	1. 2.
Diphteria or **TD** Tetanus		
Oral Polio (Sabin) **TOPV** Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubella)		
Mumps		
Rubella (German Measles, 3-day measles)		
Other Tuberculin test given _____ (most recent)		
Haemophilus influenza B (HIB)		
Hepatitis B		

Section 3: PHYSICIAN'S HEALTH EXAM **Physician to Complete**

ATTENTION PHYSICIAN: To attend Riverview Camp for Girls, a health examination within the past 12 months is required. The applicant will be participating in an active and sometimes strenuous activity schedule that will include one or more of the following: athletic participation and competition, horseback riding, gymnastics, dance, archery, riflery, water sports, ropes course, climbing tower, tennis, walking or hiking over rocky terrain, overnight camping and other general camp games and activities.

--Please insist applicant furnish complete medical history before exam.

--Please review immunizations for applicant to insure appropriate immunizations are current. Tetanus booster within last 10 years is required (unless there is a national shortage and booster is unavailable).

--After completing Section 3, summarize any restrictions and/or recommendations in Section 4. below, AND ATTACH ANY ADDITIONAL INFORMATION.

Check box if normal, circle if abnormal and attach details:

- ❑ Growth development
- ❑ Skin, glands, hair
- ❑ Head, neck, thyroid
- ❑ Ears
- ❑ Eyes
- ❑ Nose
- ❑ Teeth, tonsils
- ❑ Respiratory
- ❑ Cardiovascular
- ❑ Abdomen, hernia
- ❑ Skeletomuscular
- ❑ Neuropsychiatric

❑ **Other(specify):** _____

❑ **Comments:** _____

Height_____Weight_____Blood Pressure____/____Pulse_____

Hearing:___Normal___Abnormal Vision:___Normal ___Glasses __Contacts

Temperature:_____ Normal Temperature Range:_____

Camper is under the care of a physician for the following conditions:

Condition	Current Medication	To be continued at camp Specify dose or treatment
_____	_____	_____
_____	_____	_____

____Asthma ____Convulsions ____Heart trouble ____Contact Lenses

____Diabetes ____ Epilepsy ____Fainting ____Bleeding Disorders

____Concussion ____Loss of consciousness ___Dentures

Circle Allergies to: drugs, foods, plants, animals, insects, chemicals:

Indicate treatment to be administered. _____

Any condition that may require special care, medication, or diet:

Explain or *ATTACH* additional information _____

Section 4: PHYSICIAN'S EVALUATION AND ADVICE:

Date examined: _____

I have examined camp applicant within the past year. In my opinion the applicant's condition _____ does _____ does not permit participation in an active camp program.

Specific restrictions/Recommendations: (explain other limitations or restrictions) _____

_____

❑ ADDITIONAL INFORMATION IS ATTACHED.

Licensed Physician's Signature: _____

Address: _____ Phone: _____

Street & Number Area Code/Number

_____

City ST Zip

Date of Form Completion_____*By_____

*Initial if completed by nurse or physician's assistant

Fax: 256-634-3601 If faxing, please give Camp Riverview a call at 256-634-4043 to verify that the fax was received.

PLEASE BRING ORIGINAL FORM ON OPENING DAY OF CAMP.