

Staple together please

2017 HEALTH FORM
Complete and Return to:



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 reaction: \_\_\_\_\_

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.

Table with 3 columns: Date, Place, Phone #

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.

Camp Nurse: Initial here after review of form: \_\_\_\_\_ date: \_\_\_\_\_

Signature of Parent/Guardian or Adult Staff

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

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

Section 3: PHYSICIAN'S HEALTH EXAM Physician to Complete

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:

Table with 3 columns: Question, Yes, No, Year. Contains 40 medical conditions for screening.

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.

Table with 3 columns: Vaccines, Year of Basic Immunization, Year of Last Booster. Lists various vaccines like DTP, ID, TOPV, etc.

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.

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

Checkboxes for: Growth development, Teeth, tonsils, Skin, glands, hair, Respiratory, Head, neck, thyroid, Cardiovascular, Ears, Abdomen, hernia, Eyes, Skeletomuscular, Nose, 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: Street & Number Phone: 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.

Camper's Name: \_\_\_\_\_ Session: \_\_\_\_\_

Fax to 256-634-3601 or email to [info@riverviewcamp.com](mailto:info@riverviewcamp.com) with Insurance Card in the subject line  
Attach to your health form if at all possible

Front of insurance card goes here

Back of insurance card goes here

Front of prescription card goes here

Back of prescription card goes here