# Monterey Bay Horsemanship & Therapeutic Center

## Horse Heaven Residential Camp

## Health History and Medical Examination Form

**Health History:** 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. Health history must be filled out by parents/guardians of campers.

**Medical Examination:** A medical examination is to be completed by a licensed physician, nurse practitioner, physician's assistant or registered nurse within the preceding 24 months. Yearly update required for any medical changes.

*Please type or write clearly and legibly.*

| **Name of Camper:** (Last, First, Middle Initial) | **Date of Birth:** (mm/dd/yy) | | |
|---|---|---|---|
| **Address:** | **City:** | **St:** | **Zip:** |
| **Parent or Guardian:** | **Phone:** | **Alternate Phone:** | |
| **Parent or Guardian:** | **Phone:** | **Alternate Phone:** | |

**E-mail Address(es):** (First Name, Last Name and e-mail address) ______________________________

______________________________

**Emergency Contact Information (parent/guardian):**

| **Emergency Contact:** | **Relationship:** |
|---|---|
| **Phone:** | **Alternate Phone:** |

**Health Insurance Information**

| **Policy Holder's Name:** | **Policy Number:** |
|---|---|
| **Insurance Company Name:** | **Group Number:** |
| **Insurance Company Address:** | **Insurance Company Phone:** |

**Check all that apply and explain in detail checked answers:**

| | | | |
|---|---|---|---|
| ¨ | Diabetes | ¨ | Sleep disturbances |
| ¨ | Heart Defects/Disease | ¨ | Fainting |
| ¨ | Asthma | ¨ | Bed wetting |
| ¨ | Ear Infections | ¨ | Constipation |
| ¨ | Musculoskeletal Disorders | ¨ | Chicken Pox |
| ¨ | Convulsions/Epilepsy/Seizures | ¨ | Measles |
| ¨ | Sinusitis (Sinus Infections) | ¨ | German Measles |
| ¨ | Physical Restrictions | ¨ | Mumps |

| „ | Kidney/bladder illness | „ | Rheumatic Fever |
|---|---|---|---|
| „ | Mental/psychological disorder | „ | Tuberculosis |
| „ | Hypertension | „ | Kidney Disease |
| „ | Arthritis | „ | Eating Disorders (Anorexia, Bulimia, etc.) |
| „ | Nosebleeds | „ | Headaches/Migraines |
| „ | Has begun menstruation | „ | Had surgery or hospitalized in the last 5 years |
| „ | Menstrual cramps | „ | Currently under doctor's care |
| „ | Bleeding disorder | „ | Emotional – Separation Anxiety |
| „ | Other: | | |
| **Please explain in detail all checked answers marked above:** | | | |

**Allergies:** Please list all allergies, the type of reaction and its severity, treatment and date of last reaction. Include allergies to medications, food, bees, animals, plants, etc.

| Allergies | Reaction/ Severity | Treatment | Date of last Reaction |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Does the camper suffer from Anaphylaxis? Yes No

*Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.

Does the camper carry an Epipen or any other specific emergency device(s)? Yes No

Does the camper carry an inhaler? Yes No

Any Medic Alert in place for the camper? Yes No

**Medical Conditions** (including any precautions or restrictions on activities)

| Name of Condition | Effects |
|---|---|
| 1. | |
| 2. | |
| 3. | |

**Medications**: List any medications the camper is currently taking (or has taken in the recent past) including dosage schedule and specific instructions for use. Also, please indicate (Yes/No) if camper is allowed to take the medication on her/his own or if she/he should be monitored by an advisor. This would include any type of birth control.

**All prescriptions must be in the original container with current dosage instructions.**

| Medication | Purpose | Dosage Schedule | Specific Instructions | Self-Medicate? (Yes/No) |
| --- | --- | --- | --- | --- |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

**Over-the-Counter Medications:** My camper has permission to take over-the-counter medications in case of accident or injury. Please check all that the camper has permission to take:

- Tylenol/Acetaminophen
- Aspirin (fever reducer)
- Ibuprofen (pain/swelling)
- Benadryl/Antihistamine
- Robitussin/expectorant
- Sudafed/decongestant
- Pepto Bismol
- Tums/antacid
- Imodium (anti-diarrhea)
- Dramamine (motion sickness prevention)
- Skin Ointments (in case of rash, antibacterial, athlete's foot, etc.)
- Other: ____________________ ____________________
- Other: ____________________________________________

**Special considerations or notes regarding over-the-counter medications:**

**Does the camper have a Special Medical or Dietary Regiment to be followed?** Yes No
If so, please explain: ____________________________________________

**Has the camper ever had any adverse reactions to general anesthetics?** Yes No
If so, please explain: ____________________________________________

**Any other information not covered in this form that is important that advisors for camp staff to know:** ____________
____________________________________________

**Camper's Name:** ____________________ **Date:** ____________

***(This section is to be completed by a physician after the review of health history with parent/guardian. Parent/Guardian must complete all the information of the Health History to the best of their knowledge and sign before meeting with licensed professional.)***

**Medical Examination – Must be completed in detail.**

Height: ______ Weight: ______ B. P.: _____/_____ Hearing: R ___ L ____
Eyes: With Glasses R 20/____ L 20/_____ Without Glasses R 20/_____ L 20/_____
Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined

| | | | |
|---|---|---|---|
| ________ Nose | ________ Abdomen | ________ Urinalysis* | Other: ________________ |
| ________ Throat | ________ Hernia | ________ HGB* | ______________________ |
| ________ Teeth | ________ Genitalia | ________ Appearance/Nutrition | ______________________ |
| ________ Heart | ________ Skin | ________ General Physical State | ______________________ |
| ________ Lungs | ________ Musculoskeletal | ________ General Emotional State | ______________________ |

*Girls should have this test if she had not had it since entering puberty.

**Record of Immunization – Must be completed in detail.**

| | Date Series was Completed | Year of Last Booster | | Date Series was Completed | Year of Last Booster |
|---|---|---|---|---|---|
| Hep B | ________ | ________ | Typhoid | ________ | ________ |
| DTap/Tdap | ________ | ________ | Paratyphoid | ________ | ________ |
| DT/Td | ________ | ________ | Cholera | ________ | ________ |
| Hib | ________ | ________ | Yellow Fever | ________ | ________ |
| IPV/OPV | ________ | ________ | Typhus | ________ | ________ |
| PCV7 | ________ | ________ | Rocky Mountain Spotted Fever | ________ | ________ |
| MMR | ________ | ________ | | | |
| Varicella | ________ | ________ | Tuberculin Test: Year last given | | ________ Result ________ |
| Other: | | | Not required immunizations, but recommended | | |
| __________ | ________ | ________ | HPV | ________ | ________ |
| __________ | ________ | ________ | Rota | ________ | ________ |
| __________ | ________ | ________ | MCV4/MPSV4 | ________ | ________ |
| __________ | ________ | ________ | Hep A | ________ | ________ |
| __________ | ________ | ________ | TIV/LAIV | ________ | ________ |

Personal and religious beliefs dictate against immunizations: Yes No

**Physician Information**

| **Licensed Physician Name:** (Last, First, Middle Initial) | **Phone Number:** | | |
|---|---|---|---|
| **Address:** | **City:** | **St:** | **Zip:** |

This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted.

**Signature of Licensed Physician:** ____________________ **State License Number:** ____________ **Date:** _______

**HEALTH INFORMATION PRIVACY STATEMENT**

The **Health History and Medical Examination Form** is for health care concerns for residential horse camp. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access for the specific camp. Minimal necessary information may be shared with camp staff/volunteers in order to provide adequate participant safety and health care. Access to the information will be limited.

I have read the above procedures for handling the health and medical form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

**This Health History and Medical Examination Form is complete and accurate. My daughter/son has permission to engage in all prescribed activities, except as noted by me and the examining physician.**

**Signature of Parent/Guardian:** ______________________________ **Date:** ________________