



STAFF: PLEASE FILL OUT AND HAVE THIS FORM NOTARIZED.

Staff Name _____ D.O.B. _____ Age _____ Sex _____
Last First Middle (these are for demographics only)

Home Address _____
Street Address City State Zip

Custodial Parent/Guardian(under 18) _____ Home Phone _____

Home Address _____ City _____ State _____ Zip _____
(if different from above)

Business Address _____ City _____ State _____ Zip _____

If not available in an emergency, notify _____

Relationship _____ Phone 1 _____ Phone 2 _____

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 _____ Group# _____

➤ **Photocopy front and back of health insurance card must be attached to this form.**

IMPORTANT – THIS BOX MUST BE COMPLETE FOR ATTENDANCE

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.

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, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Sworn to and subscribed before me this

_____ Day of _____ 20_____

Signature of Staff Member Date

Notary Public _____

Signature of Parent or Guardian if under 18 Date

My Commission expires _____

HEALTH HISTORY

The following information must be filled in by the parent/guardian. 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. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List All Known

Describe reaction and management

Medication Allergies (list)

Food Allergies (list)

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

MEDICATIONS BEING TAKEN

Please list ALL medication (including over-the counter or nonprescription drugs taken routinely). Bring enough medications 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

I take NO medications on a routine basis.

I take these 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 # 2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications.

RESTRICTIONS

The following restrictions apply to this individual

Dietary

Does not eat red meat

Does not eat pork

Does not eat eggs

Does not eat poultry

Does not eat seafood

Does not eat dairy products

Other (describe) _____

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

General Questions (Explain “yes” answers below)

Has/Does the participant:

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

Yes No

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 A
- Hepatitis B
- Hepatitis C

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)		_____	_____	_____	_____	_____	_____

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. (use additional sheet if necessary)

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

EYC 2
Required Health Care Exam by Licensed Medical Personnel
2010 EVERGLADES YOUTH CONSERVATION CAMP

NAME: _____ **AGE:** _____ **DATE OF BIRTH:** _____

THIS EXAMINATION SHOULD BE PERFORMED WITHIN ONE YEAR OF ARRIVAL AT CAMP.

I examined this individual on _____

Height _____	Weight _____	Blood Pressure _____	Eyes _____
Nose _____	Teeth _____	Throat _____	Heart _____
Ears _____	Lungs _____	Abdomen _____	Skin _____

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:

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 _____

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 _____

Phone _____ Date _____

For camp use only

Screening Record

Date screened _____ Time _____

Meds Received _____

Current health needs identified _____

Observational notes _____

Screened By _____

EYC 3 – Pick Up Authorization & OTC Medication Forms

Pick up Authorization (If under 18)

Child's Name: _____ Program/Cabin Number: _____

Pick Up Release Authorization

I give permission for the following people to pick up my child on Friday (between 3:00 – 6:00 p.m.), the last day of camp. I agree that myself, or the person(s) I authorize, will check my child out with the camp administrator in the Dining Hall before leaving the grounds and I understand that I/they may be asked to show verification. _____ (Initial)

Please provide a pick-up password for your child: _____

List names and phone numbers of people including parent(s) permitted to pick-up your child: _____

Permission to Administer Over – The – Counter Medication (If Under 18)

Do not bring over-the-counter medications unless your child has allergies to some medications or uses specific brands. Only bring vitamins, if they are absolutely necessary. **They must be in the original container.** Please bring all medications (prescriptions and vitamins) when signing your child in at camp. All medications must be turned into the medical staff for distribution at the appropriate times each day.

By initialing below you are giving permission for first-aid certified staff and/or the designated medical staff to administer first-aid as well as simple over-the-counter medications for insect bites, stings, headaches, stomachaches, etc., as needed.

_____ The camp may administer any over-the-counter medication as deemed necessary by the medical staff or first-aid certified staff **or**

_____ The following over-the counter medications can be administered to my child: _____

_____ My child has no medication allergies I am aware of

_____ My child is allergic to the following medications: _____

_____ If my child forgets or loses his/her sunscreen or bug spray, the camp has my permission to apply any sunscreen or bug spray deemed necessary.

I give permission for first-aid staff and the designated medical staff at the Everglades Youth Conservation Camp to administer the above mentioned over-the-counter medications to my child. I will not hold the Everglades Youth Conservation Camp, Pine Jog Environmental Education Center or Florida Atlantic University responsible in the event of a reaction to the medication administered as per my direction. _____ (Initial)

Parent/Guardian Signature (Signature verifies all initialed above)

Date

- EYC 5 - Assumption of Risk & Photo Release

Assumption of Risk

PLEASE PRINT

Name _____ Sex _____

Address _____ Age _____

City _____ State _____ Zip _____

Home Phone _____ Office Phone _____ Cell Phone _____

I certify that I am in good health and capable of full participation in the activities of the Everglades Youth Conservation Camp. I am aware that during wilderness trips and/or instruction courses, that I am participating in under the arrangements of Pine Jog Environmental Education Center, certain dangers may occur, including but not limited to physical exertion and contact with water, plants, insects and animal life associated with out-of-doors activities, and travel by automobile or conveyance including canoes and bicycles and any type of labor or practices associated with volunteer work.

In consideration of, and as part payment for, my participation in such trips or other services and activities arranged for me by the Everglades Youth Conservation Camp, I will and do hereby assume all of the above mentioned risks, and will hold the Everglades Youth Conservation Camp, Pine Jog Environmental Education Center, Florida Atlantic University, the State of Florida and its employees, agents, officers, teachers and volunteers harmless from any and all liability, actions, causes of actions, debts, claims, demands of every kind and nature whatsoever which may arise from or in my connection with my participation in the activities.

Signature (Parental signature is required if participant is under 18)

Date: _____

ADULT PHOTO/VIDEO RELEASE FORM

I hereby give permission for my name, likeness and biographical material to be used solely for the purposes of Florida Atlantic University-related promotional material and publications, and waive any rights of compensation or ownership thereto.

Student Faculty Staff Other

Print Name: _____

Signature: _____

Street Address: _____

City/State/Zip: _____

Phone _____

Date of Signature: _____