2019 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 form to:medical@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		Yes	No	Year
1. Serious Illness	___	___	______	18. Hearing impaired	___	___	______
2. Serious Injury	___	___	______	19. Hypertension	___	___	______
3. Deformity	___	___	______	20. Convulsions	___	___	______
4. Surgery	___	___	______	21. Epilepsy	___	___	______
5. Skin Glands	___	___	______	22. Constipation	___	___	______
6. Nose Sinusitis	___	___	______	23. Athlete's Foot	___	___	______
7. Heart	___	___	______	24. Panic Attacks	___	___	______
- Murmur	___	___	______	25. Bronchitis	___	___	______
- Rheumatic Fever	___	___	______	26. Fainting	___	___	______
8. Chest, Lungs	___	___	______	27. Depression	___	___	______
9. Stomach, bowels	___	___	______	28. Sore Throats	___	___	______
10. Appendicitis	___	___	______	29. Bleeding/Clotting	___	___	______
11. Kidneys or urine	___	___	______	30. Mononucleosis	___	___	______
- Albumin	___	___	______	31. Sprains or breaks	___	___	______
- Sugar	___	___	______	32. Chicken Pox	___	___	______
- Infection	___	___	______	33. Measles	___	___	______
- Bed-wetting	___	___	______	34. German Measles	___	___	______
12. Menstrual prob.	___	___	______	35. Mumps	___	___	______
13. Hernia	___	___	______	36. Asthma	___	___	______
14. Back,limbs,joints	___	___	______	37. Tuberculosis	___	___	______
15. Sleepwalking	___	___	______	38. Other(explain)	___	___	______
16. Nervous Cond.	___	___	______	39. Hepatitis A,B,C	___	___	______
17. Eyes/Ears	___	___	______	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	1.	1.
Pertussis (Whooping Cough)	2.	2.
Tetanus or **DPT**	3.	
Tetanus		
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

Email to medical@riverviewcamp.com or 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 medical@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