

2019 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: 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

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

Scan and email to medical@riverviewcamp.com or Fax: 256-634-3601 Please call Camp Riverview at 256-634-4043 to verify that the form was received. BRING ORIGINAL ON OPENING DAY OF CAMP.

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: _____

Sex _____ Height _____ Weight _____ Sister(s) who attend Riverview: _____ Age: _____

Custodial Parent or Guardian: _____ Cell Phone: (_____) _____

Custodial Home Address: _____

Street Address Mailing Address if different from physical address City State Zip Code

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 _____

Poison Ivy/Oak/Sumac _____

Insect Stings _____

Severe (stop breathing) _____

Mild (swelling/rash) _____

Foods/possible reaction: _____

Drugs/possible reaction: _____

Where has she traveled outside the country in last 9 months? _____

The following non-prescription medications may be used on the stock in camp Health Care Center and are used on an as needed basis to manage health needs.

Cross out the items that the camper should not take:

- Acetaminophen (Tylenol), Ibuprofen (Advil, Motrin), Antihistamine/allergy meds., Ear Drops, Eye Wash, Phenylephrine (Sudafed PE), Pseudoephedrine (Sudafed), Diphenhydramine (Benadryl), Generic Cough Drops, Sore throat spray, Calamine lotion, Laxatives for constipation, Hydrocortisone 1% and topical antibiotic cream, Hydrogen Peroxide, Alcohol, Insect Repellent, Guaifensin/Dextromethorphan (for cough), Anti-Acids(Tums/Roloids), Chlorpheniramine maleate (Flonase), Dramamine, Bismuth subsalicylate for diarrhea/nausea (Kaopectate, Children's Pepto Bismal, Nauseze)

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 #

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. If I pay for an out of camp trip, I give permission for my child to be transported to the location. **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 or health providers 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 information or records necessary to staff on a "needs to know basis" or to others for treatment, referral, billing, or insurance.

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

Name: _____
 Address: _____ City, _____ State _____ Zip _____

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:

	Yes	No	Year		Yes	No	Year
1. Serious Illness	___	___	___	19. Hypertension	___	___	___
2. Serious Injury	___	___	___	20. Convulsions	___	___	___
3. Deformity	___	___	___	21. Epilepsy	___	___	___
4. Surgery	___	___	___	22. Constipation	___	___	___
5. Skin Glands	___	___	___	23. Athlete's Foot	___	___	___
6. Nose Sinusitis	___	___	___	24. Panic Attacks	___	___	___
7. Heart	___	___	___	25. Bronchitis	___	___	___
- Murmur	___	___	___	26. Fainting /Dizziness	___	___	___
- Rheumatic Fever	___	___	___	27. Depression	___	___	___
8. Chest, Lungs	___	___	___	28. Sore Throats	___	___	___
9. Stomach, bowels	___	___	___	29. Bleeding/Clotting	___	___	___
10. Appendicitis	___	___	___	30. Mononucleosis	___	___	___
11. Kidneys or urine	___	___	___	31. Sprains or breaks	___	___	___
- Albumin	___	___	___	32. Chicken Pox	___	___	___
- Sugar	___	___	___	33. Measles	___	___	___
- Infection	___	___	___	34. German Measles	___	___	___
- Bed-wetting	___	___	___	35. Mumps	___	___	___
12. Menstrual prob.	___	___	___	36. Asthma	___	___	___
13. Hernia	___	___	___	37. Tuberculosis	___	___	___
14. Back,limbs,joints	___	___	___	38. Other(explain)	___	___	___
15. Sleepwalking	___	___	___	39. Hepatitis A,B,C	___	___	___
16. Nervous Cond.	___	___	___	40. ADHD/ADD	___	___	___
17. Eyes/Ears	___	___	___	41. Headaches	___	___	___
18. Hearing impaired	___	___	___	43. Seizures	___	___	___
				44. Diabetic	___	___	___
45. Are you aware of any current health problem?	___	Yes ___	No ___				
46. Now under medical care or taking medications?	___	Yes ___	No ___				
47. Emotional or Behavioral difficulties, eating disorder	___	Yes ___	No ___				
48. Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination?	___	Yes ___	No ___				

Details: Yes Answers, (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 infectious disease during the three weeks prior to camp. URGENT FOR THE WELL-BEING OF ENTIRE CAMP.

Section 2: IMMUNIZATION HISTORY Attach or 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, Tetanus, Pertussis (Whooping Cough) (DTaP) or TdaP	1.	Dose 2. Dose 3. Dose 4. Dose 5.
Tetanus Booster * (MUST INCLUDE DATE TO MEET ACA STANDARD) (dT) or TdaP		
Varicella (Chicken Pox) Had Chicken Pox? _____ Date: _____		
Oral Polio (PV)		
Injectable Polio (Salk)		
Mumps, Measles, Rubella, (MMR)		
Hepatitis B		
Hepatitis A		
Meningococcal meningitis (MCV4)		
Haemophilus influenza B (HIB)		
Tuberculin test given _____ (most recent) TB Test _____ Negative _____ Positive		

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).

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

- | | |
|--|---|
| <input type="checkbox"/> Growth development | <input type="checkbox"/> Teeth, tonsils |
| <input type="checkbox"/> Skin, glands, hair | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Head, neck, thyroid | <input type="checkbox"/> Cardiovascular |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Abdomen, hernia |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Skeletomuscular |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Neuropsychiatric |
| <input type="checkbox"/> Other(specify): _____ | |
| <input type="checkbox"/> 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 ___ADD OR ADHD

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 here if completed by nurse or physician's assistant _____

Scan and email to medical@riverviewcamp.com or Fax: 256-634-3601 |

Please give Camp Riverview a call at 256-634-4043 to verify that the form was received.

PLEASE BRING ORIGINAL FORM ON OPENING DAY OF CAMP. Page 2

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