Achievement Centers for Children

THE ACHIEVEMENT CENTERS FOR CHILDREN
RECREATION DEPARTMENT

HEALTH HISTORY and PHYSICAL EXAM REPORT

Date of Physical Exam

Date_____

Section One is to be filled out by the client, parent and/or guardian.
Section Two is to be filled out by a Physician, Advance Practice Nurse (APN), or Nurse Practitioner.

Section One: Client Health History

Client Name _____ D.O.B. ____/____/____

Address _____ Phone (____) _____

City _____ State _____ Zip _____

Male: _____ Female: _____ Height: _____ Weight: _____

Diagnosis:

Primary: _____

Secondary: _____

Other: _____

Immunization Record (required for persons 18 years and younger)
Please fill out the form below or attach a printed record from the physician.

Vaccine	First Month/Year	Second Month/Year	Third Month/Year	Fourth Month/Year	Most Recent Dose Month/Year
DTaP or TdaP					
Hib					
IPV					
MMR					
HEP B					

Other(s) if they have been given:

- **Tuberculosis (TB) Test** (recommended every two years, but not mandatory) Yes____ Most recent test date:_____ No:____
  Negative: _____ Positive: _____
- **Meningococcal Meningitis (MCV4) : Yes:**_____ Date: _____ No:_____
- **Tetanus (dt) or (TdaP):** Yes:_____ Date: _____ No: _____
- **Varicella**: Yes:_____ Date: _____ No:_____ Had Chicken Pox: Date: _____

DIET,NUTRITION,FOOD	If yes, please explain:	
Food Allergy	No_____ Yes_____	
Food Restrictions	No_____ Yes_____	
Lactose Intolerant	No_____ Yes_____	
Gluten Intolerant	No_____ Yes_____	
Vegetarian Diet	No_____ Yes_____	
Other	No_____ Yes_____	

ALLERGIES	If yes, please explain what allergy signs appear and how you treat them	
Bee/wasp stings	No_____ Yes_____	
Pollen/Plants	No_____ Yes_____	
Poison Ivy	No_____ Yes_____	
Animals	No_____ Yes_____	
Milk	No_____ Yes_____	
Latex Products	No_____ Yes_____	
Sun Sensitivity	No_____ Yes_____	
Penicillin	No_____ Yes_____	
Other Medication(s)	No_____ Yes_____	
Other Allergies	No_____ Yes_____	

Section 1:

General Health History: Check "Yes" or "No" for each statement. Please explain "Yes" answers.	
Has/does the client:	9. Had fainting or dizziness? No_____ Yes_____
1. Ever been hospitalized? No_____ Yes_____	10. Passed out/had chest pain during exercise? No_____ Yes_____
2. Ever had surgery? No_____ Yes_____	11. Had mononucleosis (mono) during the past 12 months? No___ Yes___
3. Have recurrent/chronic illness No_____ Yes_____	13. If female, have problem with periods/menstruation? No___ Yes___
4. Had a recent infectious disease? No_____ Yes_____	14. Had problems with falling asleep/sleepwalking? No_____ Yes____
5. Had a recent Injury? No_____ Yes_____	15. Ever had back/joint problems? No_____ Yes_____
6. Had asthma/wheezing/shortness of breath? No_____ Yes_____	16. Have a history of bedwetting? No_____ Yes_____
7. Have diabetes? No_____ Yes_____	17. Have problems with diarrhea/constipation: No_____ Yes_____
8. Had headaches? No_____ Yes_____	18. Have any skin problems? No____ Yes_____
Please explain "Yes" answers in the space below, noting the number of the question(s).	

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.
Has the client:

1. Ever been diagnosed with or treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? No____ Yes____
2. Ever been diagnosed with or treated for emotional or behavioral difficulties or an eating disorder? No____ Yes____
3. During the past 12 months, seen a professional to address mental/emotional health concerns? No____ Yes____
4. Had a significant life event that continues to affect the camper's life? No____ Yes____
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the question(s). The agency may contract you for additional information.

Seizure Data:
Does client have **seizures**: No: ____ Yes: ____ Date of last seizure: _____ Are seizures controlled? No_____ Yes: ____

Please describe the seizure and provide the seizure plan of action if one would occur:

Does the client have any communicable disease(s)? No: _____ Yes: _____ Please explain:
_____
_____
_____

Section 1:

Medication:

☐ **NO**, the client will not be taking any prescription medication while attending camp.

☐ **YES**, the client will take the following prescription medication while at camp:

"Medication" is any substance a person takes to maintain and/or improve health. This includes vitamins & nature remedies. Please list all medications the client is on, not just the medication(s) they may be taking while at camp. **All medications brought to camp must be in the original containers with labels which show the client's name, correct dose, and when the medication is to be given**. Provide only enough of each medication to last the entire time the client will be at camp.

Name of Medication	When is it given	Amount or Dose given	How it is given
	○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other Time:		
	○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other Time:		
	○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other Time:		
	○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other Time:		
	○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other Time:		
	○ Breakfast ○ Lunch ○ Dinner ○ Bedtime ○ Other Time:		

Non-Prescription Medication:

The following non-prescription medications are commonly stocked in the camp Health Center and are used on an as needed basis to manage illness and/or injury.

☐ **NO**, the client does not have my permission to take any non-prescription medication while at camp.

☐ **YES**, the client has my permission to take the following non-prescription medication, as needed, at camp.

Please **cross off** the non- prescription medication the client **should not** be given noted below.

Note: liquid preparations will be substituted, when available, for clients unable to swallow pills.

Medication	Adult Dose	Child Dose	Frequency	Symptoms Used to Treat
Acetaminophen	325mg tab x 1-2 tablets by mouth	By weight 1kg = 2.2 lb. 10-15 mg/kg every 4-6 hours max. 3,000 mg/day	Every 4-6 hrs as needed max 3,000 per day	For headache, muscle aches, menstrual cramps, fever, aches/pains of cold or flu
Bismuth Subsalicylate or Pepto-Bismol	524 mg (not to exceed 8 doses in 24 hours)	6-9 years.: 175 mg 9-12 years.: 262 mg	1 every 30-60 minutes as needed (not to exceed 8 doses in 24 hours)	Diarrhea or upset stomach
Bug Spray	Apply to skin with a cotton ball	N/A	Apply to skin and clothing as needed	To prevent bug bites
Calamine lotion	Apply to skin with a cotton ball	Apply to skin with a cotton ball	Apply as often as necessary throughout the day	Soothing and protecting the skin following minor skin irritations (itching, pain, and discomfort) including poison ivy, poison oak, and poison sumac
Chloraseptic	Spray 5 times	12 + years.: 5 sprays	1 spray every 2 hours as needed	Sore throat pain

Medication	Adult Dose	Child Dose	Frequency	Symptoms Used to Treat
Cough drops/throat lozenges	Take 1 by mouth	N/A	every 1 hr as needed	To suppress cough and/or soothe cough-irritated throat
Dextromethorphan	Capsule, liquid, tablet or syrup – 10 to 30 mg orally	Capsule, liquid, tablet or syrup – 7-12 years.: 5 to 10 mg; 12+ years. : 10 to30 mg orally	1 every 4-8 hours as needed	Cough suppressant
Diphenhydramine or Benadryl	25 mg capsule x 1-2 capsules orally	6-11 years.: 1 tsp (5ml) to 2 tsp (10 ml)	Every 4-6 hours as needed	Runny nose, sneezing, itching of nose/throat, and/or watery eyes due to upper respiratory allergies; runny nose, sneezing associated with common cold; bee stings if localized swelling
Guaifenesin or Mucinex	Immediate release formula 200-400 mg (not to exceed 2.4 g daily)	Immediate release formula 6-11 years. 100-200 mg (not to exceed 1.2 g daily) 12+ years. : 200-400 mg (not to exceed 2.4g daily)	every 4 hours as needed	Cough
Hydrocortisone (cream, ointment, lotion, gel)	0.5% or 1%	0.5% or 1%	as needed up to 4 times daily.	Provide temporary relief of (1) minor skin irritation, itching, and rashes caused by eczema, insect bites, poison ivy, poison oak, poison sumac, soaps, detergents, cosmetics, and jewelry; (2)itchy anal and rectal areas; and 93) itching and irritation of the scalp
Ibuprofen	200 mg tab x 1-2 tab by mouth	36-47 lbs (4-5 years.): 1 ½ tsp (7.5 ml) 48-59 lbs (6-8 years.):2 tsp (10 ml); 60-71 lbs (9-10 years.): 2 ½ tsp (12.5 ml) 72-95 lbs (11 years.) 3 tsp (15 ml)	6-8 hours as needed (not more than 4 times a day)	Headache, toothache, muscular aches, backaches, menstrual cramps, fever associated with cold/flu
Imodium Multi-Symptom Relief	2 tablets with water after first stool, 1 tablet with water after subsequent loose stool (do not exceed 4 tablets in 24 hours)	6-8 years.: 1 tablet with water after first stool, ½ tablet with water after subsequent loose stool (do not exceed 2 tablets in 24 hours) 9-11 years:: 1 tablet with water after first stool, ½ tablet with water after subsequent loose stool (do not exceed 3 tablets in 24 hours) 12+ years.: 2 tablets with water after first stool, 1 tablet with water after subsequent loose stool (do not exceed 4 tablets in 24 hours)	after each loose stool as needed (not to exceed maximum daily dosage)	Diarrhea
Neosporin	Ointment or cream	Ointment or cream	Apply 1 – 3 x daily	Treating and preventing infection due to minor cuts, scrapes, and burns
Phenylephrine	15 mg/10 ml oral liquid (not to exceed 60 mg daily)	6-11 years.: 7.5 mg (not to exceed 30 mg daily) 12 + years.: 15 mg (not to exceed 60 mg daily)	every 6 hours as needed	Nasal Congestion (decongest)
Sunscreen	N/A	N/A	Apply to skin every 4 hours as needed	To prevent sunburn
Swim Ear Otic Drops	X 3-6 drops in one or both ears	X 3-6 drops in one or both ears	Every 6-8 hours prn	Complaint of water caught in ear canal after swimming

Recommended Restrictions, Please check off any restrictions:

- ☐ Participation in Physical Activities _____
- ☐ Wheelchair exercises _____
- ☐ Adapted contact sports _____
- ☐ Swimming events_____
- ☐ Overnight camp outs _____
- ☐ High Ropes course _____
- ☐ Low Ropes course _____
- ☐ Horseback riding _____

Section 1:

Client/Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the client to whom it pertains. The person described has permission to participate in all recreation activities except as noted by me and/or an examining physician. I give permission to the authorized medical staff to distribute all prescription and over-the-counter medications. I give permission to the authorized medical staff to give treatment related to health of my child for both routine health care and in emergency situations. I understand the information on this will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of the client's health record from providers who treat the client and these providers may talk with the program's staff about my/my child's/my client's health status.

Signature of Client/Parent/Guardian_____ Date: _____

Client/Parent/Guardian: STOP here. The rest of the form is to be completed and signed by a physician or APN or Nurse Practitioner.

Section Two: Medical Personnel

This section is to be filled out by a Physician, Advance Practice Nurse (APN), or Nurse Practitioner. Please review the CLIENT HEALTH HISTORY FORM and complete all remaining sections of this form. Attach additional information if needed.

Physical Exam done today: Yes_____ No____ (If "No", date of last physical: _____)
Month/Date/Year
ACA accreditation standards specify physical exam within the last 12 months.

Allergies:

No Known Allergies	No_____ Yes_____
To foods:	No_____ Yes_____
To medications:	No_____ Yes_____
To the environment (insect stings, hay fever, etc.)	No_____ Yes_____
Other allergies:	No_____ Yes_____

Please explain "Yes" answers in the space below, noting the number of the question(s).

The client is undergoing treatment at this time for the following condition(s): (describe below) None_____

Medications:

☐ **NO** daily medications are taken.
☐ **YES**, the client will take the following prescribed medication(s) while at camp: **(medication, dose, frequency—describe below)**

Non-Prescription Medication:
The following non-prescription medication are commonly stocked in the camp Health Center and are used on an as needed basis to manage illness and/or injury.

☐ **NO**, the client does not have my permission to take any non-prescription medication while at camp.

☐ **YES**, the client has my permission to take the following non-prescription medication, as needed, at camp.

Please **cross off** the non-prescription medication the client **should not** be given.

Note: liquid preparations will be substituted, when available, for clients unable to swallow pills.

Medication	Adult Dose	Child Dose	Frequency	Symptoms Used to Treat
Acetaminophen	325mg tab x 1-2 tablets by mouth	By weight 1kg = 2.2 lb. 10-15 mg/kg every 4-6 hours max. 3,000 mg/day	Every 4-6 prn as needed. Max 3,000 per day	For headache, muscle aches, menstrual cramps, fever, aches/pains of cold or flu
Bismuth Subsalicylate or Pepto-Bismol	524 mg (not to exceed 8 doses in 24 hours)	6-9 years.: 175 mg 9-12 years.: 262 mg	1 every 30-60 minutes as needed (not to exceed 8 doses in 24 hours)	Diarrhea or upset stomach
Bug Spray	Apply to skin with a cotton ball	N/A	Apply to skin and clothing as needed	To prevent bug bites
Calamine lotion	Apply to skin with a cotton ball	Apply to skin with a cotton ball	Apply as often as necessary throughout the day	Soothing and protecting the skin following minor skin irritations (itching, pain, and discomfort) including poison ivy, poison oak, and poison sumac
Chloraseptic	Spray 5 times	12 + years.: 5 sprays	1 spray every 2 hours as needed	Sore throat pain

Medication	Adult Dose	Child Dose	Frequency	Symptoms Used to Treat
Cough drops/throat lozenges	X 1 by mouth	N/A	Every 1 hr as needed	To suppress cough and/or soothe cough-irritated throat
Dextromethorphan	Capsule, liquid, tablet or syrup – 10 to 30 mg orally	Capsule, liquid, tablet or syrup – 7-12 years.: 5 to 10 mg; 12+ years. : 10 to30 mg orally	1 every 4-8 hours as needed	Cough suppressant
Diphenhydramine or Benadryl	25 mg capsule x 1-2 capsules orally	6-11 years.: 1 tsp (5ml) to 2 tsp (10 ml)	Every 4-6 hours as needed	Runny nose, sneezing, itching of nose/throat, and/or watery eyes due to upper respiratory allergies; runny nose, sneezing associated with common cold; bee stings if localized swelling
Guaifenesin or Mucinex	Immediate release formula 200-400 mg (not to exceed 2.4 g daily)	Immediate release formula 6-11 years. 100-200 mg (not to exceed 1.2 g daily) 12+ years. : 200-400 mg (not to exceed 2.4g daily)	Every 4 hours as needed	Cough
Hydrocortisone (cream, ointment, lotion, gel)	0.5% or 1%	0.5% or 1%	as needed up to 4 times daily	Provide temporary relief of (1) minor skin irritation, itching, and rashes caused by eczema, insect bites, poison ivy, poison oak, poison sumac, soaps, detergents, cosmetics, and jewelry; (2)itchy anal and rectal areas; and 93) itching and irritation of the scalp
Ibuprofen	200 mg tab x 1-2 tab by mouth	36-47 lbs (4-5 years.): 1 ½ tsp (7.5 ml) 48-59 lbs (6-8 years.):2 tsp (10 ml); 60-71 lbs (9-10 years.): 2 ½ tsp (12.5 ml) 72-95 lbs (11 years.) 3 tsp (15 ml)	Quantity 6-8 hours prn (not more than 4 times a day)	Headache, toothache, muscular aches, backaches, menstrual cramps, fever associated with cold/flu
Imodium Multi-Symptom Relief	2 tablets with water after first stool, 1 tablet with water after subsequent loose stool (do not exceed 4 tablets in 24 hours)	6-8 years.: 1 tablet with water after first stool, ½ tablet with water after subsequent loose stool (do not exceed 2 tablets in 24 hours) 9-11 years.: 1 tablet with water after first stool, ½ tablet with water after subsequent loose stool (do not exceed 3 tablets in 24 hours) 12+ years.: 2 tablets with water after first stool, 1 tablet with water after subsequent loose stool (do not exceed 4 tablets in 24 hours)	after each loose stool as needed (not to exceed maximum daily dosage)	Diarrhea
Neosporin	Ointment or cream	Ointment or cream	Apply 1 – 3 x daily	Treating and preventing infection due to minor cuts, scrapes, and burns
Phenylephrine	15 mg/10 ml oral liquid (not to exceed 60 mg daily)	6-11 years: 7.5 mg (not to exceed 30 mg daily) 12 + years.: 15 mg (not to exceed 60 mg daily)	every 6 hours as needed	Nasal Congestion (decongest)
Sunscreen	N/A	N/A	Apply to skin every 4 hours as needed	To prevent sunburn
Swim Ear Otic Drops	X 3-6 drops in one or both ears	X 3-6 drops in one or both ears	Every 6-8 hours as needed	Complaint of water caught in ear canal after swimming

Other medical treatments/therapies to be continued at camp: (describe below) None needed_____

Section 2:

Seizure Data:
Does client have **seizures**: No: ____ Yes: ____ Date of last seizure: _____ Are seizures controlled? No_____ Yes: ____

Please fill out the seizure treatment plan for client with seizures.

Seizure Treatment Plan:

Diazepam rectal gel (DIASTATE® AcuDial™) _____ mg rectally prn for:

- Seizure > _____ minutes OR for _____ or more seizures in _____ hour(s).
- Use VNS (vagal nerve stimulator) magnet: _____
- Other:_____
- Call 911 if [please check all that apply]:
  - ☐ Seizure does not stop by itself or with VNS within _____ minutes
  - ☐ Seizure does not stop within _____ minutes of administering Diazepam rectal gel (DIASTATE® AcuDial™)
  - ☐ Child does not start to wake up within _____ minutes after seizure is over (No (DIASTATE® AcuDial™) is given
  - ☐ Child does not start to wake up within_____ minutes after seizure is over after (DIASTATE® AcuDial™) is given.
- Following a seizure [please check all that apply]:
  - ☐ Client should rest in health center
  - ☐ Parents/Caregiver should be notified immediately
  - ☐ Client may return to normal activity
  - ☐ Parents/Caregiver should receive a copy of the seizure record sent home with the client

**** For Persons with Down Syndrome****

☐ Upon an examination this individual did not reveal atlantoaxial instability or focal neurologic disorder.

☐ **I certify, to my knowledge that this person <u>can</u> participate in supervised horsemanship riding, adapted sports and/or Camp activities.** However, I understand that the Achievement Centers for Children will weigh the medical information above against the existing precautions and contraindications.

☐ I certify to my knowledge that this person **<u>cannot</u>** participate in supervised horsemanship riding, adapted sports and/or camp activities.

Name of Client: _____

Name of Licensed Provider (Print Please): _____

Signature (REQUIRED): _____

Address: _____

Phone: (_____)_____

Date (REQUIRED): _____