Association of Horizon, Inc.
Health Examination Form 2015
Due: June 1, 2015

RETURN FORM TO:

Jen Hanenburg
Association of Horizon Recruitment - **Camper**
1970 Harvard Lane
New Lenox, IL 60451-3804
(815) 717-8275

Attn: Sheila Caplis
Association of Horizon Recruitment - **Attendant**
2121 W Bradley Place
Chicago, IL 60618-4909
(773) 919-8378

NAME: ______________________________________ **DATE OF BIRTH:** ___________________
ADDRESS: ______________________________________ **TELEPHONE:** ___________________
EMERGENCY CONTACT:___________________________ **RELATIONSHIP:** ___________________
If applicant is under 18 years of age this must be parent or guardian!
TELEPHONE: (home) _____________________________ **(other)** ___________________________

Please supply all information requested. The purpose of this form is to give information to the camp health care staff to assist them in assuring a safe week for each person at camp, and to be able to provide efficient care in case of emergency.

Do you have completed advance directives? (Living Will, Power of Attorney for health care) YES / NO
If yes, please list ______________________________ and include copies of them with this form.

HEALTH HISTORY

Have you ever experienced any of the following illnesses or conditions?

		Allergy to:		**Infectious Diseases:**	
Ear or Eye Problems	YES / NO	Sulfa Drugs	YES / NO	Chicken Pox	YES / NO
Swallowing Difficulty	YES / NO	Latex	YES / NO	Measles	YES / NO
Stomach Problems	YES / NO	Penicillin	YES / NO	Rubella	YES / NO
Heart Problems	YES / NO	Insect Stings	YES / NO	Mumps	YES / NO
High Blood Pressure	YES / NO	Asthma or Bronchitis	YES / NO	Hepatitis	YES / NO
Diabetes	YES / NO	Pollen, Grasses	YES / NO	Tuberculosis	YES / NO
Breathing Difficulty	YES / NO	Food	YES / NO		
Cancer	YES / NO	List ______________________		**For Women Only:**	
Urinary Tract Infection	YES / NO	Medicine	YES / NO	Menstruation Problems	YES / NO
Constipation	YES / NO	List ______________________		Pregnant (now)	YES / NO
Seizures	YES / NO				

Give details of above and any serious or chronic conditions or operations that you have had, please include dates if possible:____
____
____

MEDICATION **(If more room is needed, please attach medication list to this form.)**

If you are taking any medications, please list below:

Name of Medication	Dose/Amount	How often?	How long have you been taking?

Do you have any emotional or medical problems that may affect your functioning at camp? YES / NO
If yes, please explain:____
____

Do you have a physical disability in need of accommodation? YES / NO
If yes, please explain what the disability is and how it affects your functioning?
____
____

IMMUNIZATION HISTORY (list dates If possible)

Polio (OVP) ______________ **Hepatitis B (HPV)** ______________
Influenza ______________ **Diphtheria, Tetanus, Pertussis (DTP)** ______________
Measles, Mumps, Rubella (MMR) ______________ **Tetanus Booster (Td)** ______________
Pneumococcal ______________
Last Tuberculin (TB) Skin Test ______________ **(The TB test results were: Positive / Negative)**

List physicians or other health care providers who provide care to you:

NAME **TELEPHONE** **TYPE OF CARE RECEIVED**

____

____

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HEALTH EXAMINATION This section is to be completed by a licensed physician or other health care professional.

HT: ____________ **WT:** ____________ **B/P:** ______________ **Temp:** ____________ **Heart rate:** ____________

Normal **OR** **Essential Finding, Deviating From Normal**

Head: ____
Eyes/Vision: ____
Mouth/Teeth: ____
Ears/Hearing: ____
Neck/Thyroid: ____
Heart: ____
Thorax/Lungs: ____
Abdomen/Hernia: ____
Lymphatics: ____
Spine/Posture: ____
Extremities: ____
Skin/Wounds: ____
Mental Health: ____
Emotional: ____

General Appraisal or Diagnosis:____

____

Recent Respiratory Infection? YES / NO If yes, give details:______________________________

____

Recent Hospitalization or Surgery? YES / NO If yes, give details:______________________________

____

Nutritional Needs:____

____

Other:____

____

Recommendations and Restrictions during the camp week:______________________________

____

The person named on this form wishes to participate in a camping program for persons with physical disabilities. Participation involves being outdoors and engaging in physical activities such as swimming and boating. Persons without physical disabilities may be required to do lifting. Please determine whether or not you consider this person physically and emotionally able to participate, and identify any specific restrictions that are required.

In your estimation, is this person able to attend and participate in a camping program, except as identified by your recommendations and restrictions? YES / NO

I have examined the person herein described and have reviewed her/his health history.

Examiner's Signature: ______________________________ **Date:**______________
Print Name: ____
Address: ____
City: ______________________ **State:** ________ **Zip:** __________ **Telephone:** ______________