

# ASSOCIATION OF HORIZON INC. HEALTH EXAMINATION FORM 2008

**RETURN FORM TO:** Terry Smith  
Horizon Recruitment Committee - **Camper**  
2339 W. 107<sup>th</sup> Place  
Chicago, IL 60643-3121  
(773) 445-9884 (773) 415-9884 (cell)

Attn: Shelia Caplis  
Horizon Recruitment Committee - **Volunteer**  
2121 W Bradley Place  
Chicago, IL 60618-4909  
(773) 929-8378

**NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_ **TELEPHONE:** \_\_\_\_\_  
**NAME OF EMERGENCY CONTACT:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_  
**If applicant is under 18 years of age this must be parent or guardian!**  
**TELEPHONE: (home)** \_\_\_\_\_ **(work)** \_\_\_\_\_

Please supply all information requested. The purpose of this form is to give information to 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. If you would like to speak to a member of the health care staff prior to camp to discuss your needs or to provide confidential information, please call *Margaret Sutton @ 708-423-8760*.

**Do you have a completed advance directives (living will, power of attorney for health care) YES / NO**  
**If you YES – list \_\_\_\_\_ please include copies of these with this form.**

**HEALTH HISTORY**

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

Ear or Eye problems	YES / NO	Allergy to:		Infectious Diseases:	
Swallowing difficulty	YES / NO	Food	YES / NO	Chicken Pox	YES / NO
Stomach Problems	YES / NO	Medicine	YES / NO	Measles	YES / NO
Heart Problems	YES / NO	Pollen, grasses	YES / NO	Rubella	YES / NO
High Blood Pressure	YES / NO	Insect Stings	YES / NO	Mumps	YES / NO
Diabetes	YES / NO	Asthma or bronchitis	YES / NO	Hepatitis	YES / NO
Breathing Difficulty	YES / NO	Penicillin	YES / NO	Tuberculosis	YES / NO
Cancer	YES / NO	Latex	YES / NO		
Urinary tract infection	YES / NO	Sulfa Drugs	YES / NO	<b>For women only-</b>	
Constipation	YES / NO			menstruation problems	YES / NO
Seizures	YES / NO			Pregnant (now)	YES / NO

**Give details of above and any serious or chronic conditions or operations that you have had. (give dates if possible).**

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**Medications: If you are taking any medications, please list: BRING enough for a week!**  
**name of medication                      dose/amount    how often                      how long have you been taking?**

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**Do you have any emotional or medical problems that may affect your functioning at camp? Yes No If yes please explain**

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**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?**

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

<b>NAME</b>	<b>TELEPHONE</b>	<b>TYPE OF CARE RECEIVED</b>
_____	_____	_____
_____	_____	_____

# 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 was done on: \_\_\_\_\_ of the test were ----- NEGATIVE POSITIVE

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**HEALTH EXAMINATION:** 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: \_\_\_\_\_  
 EMOTIONAL: \_\_\_\_\_  
 General appraisal or diagnosis: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Recent respiratory infection? NO YES, detail:

\_\_\_\_\_  
 \_\_\_\_\_

Recent hospitalization or surgery? NO YES, detail:

\_\_\_\_\_  
 \_\_\_\_\_

**MEDICATIONS (see other side for self report)**

\_\_\_\_\_  
 \_\_\_\_\_

**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**

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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: \_\_\_\_\_