Association of Horizon, Inc.
Health Examination Form 2017
Due: June 1, 2017

RETURN FORM TO:

Jen Hanenburg
Association of Horizon Recruitment - **Camper**
1970 Harvard Lane
New Lenox, IL 60451-3804
773-477-5170

Attn: Sheila Caplis
Association of Horizon Recruitment - **Attendant**
4537 N. Mozart
Chicago, IL 60625-8937
773-477-5170

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?

Ear or Eye Problems	YES / NO	**Allergy to:**		**Infectious Diseases:**	
Swallowing Difficulty	YES / NO	Sulfa Drugs	YES / NO	Chicken Pox	YES / NO
Stomach Problems	YES / NO	Latex	YES / NO	Measles	YES / NO
Heart Problems	YES / NO	Penicillin	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	Pollen, Grasses	YES / NO	Tuberculosis	YES / NO
Cancer	YES / NO	Food	YES / NO		
Urinary Tract Infection	YES / NO	List _____		**For Women Only:**	
Constipation	YES / NO	Medicine	YES / NO	Menstruation Problems	YES / NO
Seizures	YES / NO	List _____		Pregnant (now)	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**

_____

_____

****

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:** _____