



**Association of Horizon, Inc.  
Health Examination Form 2018  
Due: June 1, 2018**

**RETURN FORM TO:** Jen Hanenburg      Sheila Caplis  
 Association of Horizon Recruitment - **Camper**      Association of Horizon Recruitment - **Attendant**  
 1970 Harvard Lane      4537 N. Mozart  
 New Lenox, IL 60451-3804      Chicago, IL 60625-8937  
 773-477-5170      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 team 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	<b>Allergy to:</b>		<b>Infectious Diseases:</b>	
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 _____		<b>For Women Only:</b>	
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:**

<b>Name of Medication</b>	<b>Dose/Amount</b>	<b>How often?</b>	<b>How long have you been taking?</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**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)	_____
Pneumococcal	_____	Measles, Mumps, Rubella (MMR)	_____

**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: \_\_\_\_\_

Head: \_\_\_\_\_ Normal OR Essential Finding, Deviating From Normal

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: \_\_\_\_\_