Health History and Examination Form for Children, Youth and Adults Attending Camp

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history must be filled out by parents/guardians of minors. An updated form is required annually.

Dates of Camp Attendance: ___________________

Mail this form to the address below by: ________
Pali Institute
PO Box 2237
Running Springs, CA 92382

Name ________________________________ Birth Date ____________________ Age at Camp ________

Home Address ____
Street Address City State Zip

Custodial Parent/Guardian_________________________________ Phone __________________________

Home Address ____
(If different from above) Street Address City State Zip

Business Address ____ Phone __________________________
Street Address City State Zip

Second Parent/Guardian or Emergency Contact ____

Home Address ____
Street Address City State Zip

Business Address ____ Phone __________________________
Street Address City State Zip

If not available in an emergency, notify:
Name ____

Relationship ____ Phone __________________________

Address ____
Street Address City State Zip

Insurance Information
Is the participant covered by family medical/hospital insurance? ❒ Yes ❒ No
If so, indicate carrier/plan name __________________________________ Group ________________________
Name of family physician ____ Phone ________________________
Name of family dentist/orthodontist _________________________________ Phone ________________________

***Photocopy of front and back of health insurance card must be attached to this form**

IMPORTANT – THESE BOXES MUST BE COMPLETED FOR ATTENDANCE

Parent/Guardian Authorizations: The health history is correct and complete to the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to Pali Institute to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to Pali Institute to arrange necessary related transportation. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by Pali Institute to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staffer ____
Printed Name____ Date ______________________________

I give my child _______________ permission to travel under the supervision of one or more persons authorized by Pali Institute. I hereby release Pali Institute, its owners, officers, agents and employees from any and all liability. I also agree to allow my child to be used in any or all promotional photographs and videos.

Signature of parent/guardian or adult camper/staffer ____
Printed Name ____ Date ______________________________

Office Use Only
Name ______________ Cabin/Group ______________ Year ______________

Health History

Please give all dates of immunization for:

Vaccine	Dates (Mo/Yr)					
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diptheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
MMR	_____	_____				
Or Measles	_____	_____				
Or Mumps	_____	_____				
Or Rubella	_____	_____				
Haemophilius influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Vericella (chicken pox)	_____	_____				

Which of the following has the participant had? (Give date)

❒ Chicken Pox ___________
❒ Measles ___________
❒ German Measles ___________
❒ Mumps ___________
❒ Hepatitis A ___________
❒ Hepatitis B ___________
❒ Hepatitis C ___________

General Medical information

Operations or serious injuries (dates) ____

Chronic recurring illness or medical condition ____

Dietary restrictions ____

Allergies (medication, food, others) ____

Has/does your child have/had any of the following:

❒ Frequent Ear Infections ❒ Heart Defect/Disease ❒ Convulsions ❒ Diabetes ❒ Head Injury
❒ Frequent Headaches ❒ Hypertension ❒ Mononucleosis ❒ Asthma ❒ Wear Glasses/Contacts
❒ Bleeding/Clotting disorders ❒ Sleepwalking ❒ Eating Disorder ❒ Bedwetting ❒ Orthodontic Appliance

Please explain any 'yes' answers ____
____
____

Over the counter medications

I _____________________ hereby give permission for Pali Institute to administer the following over-the-counter medications if the nurse deems it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

Headaches – Tylenol *Upset Stomach – Pepto Bismol* *Diarrhea – Immodium AD*
Menstrual Cramps – Ibuprophen *Poison Ivy – Calamine Lotion or CortAid*

Signed __________________________________ Date ______________________

Medications Being Taken

Please list ALL medications (including over the counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

❒ This person takes NO medications on a routine basis

❒ This person takes medication as follows:

Med #1 __________________________________ Dosage ______________ Specific times taken each day _____________________

Reason for taking ____

Med #2 __________________________________ Dosage ______________ Specific times taken each day _____________________

Reason for taking ____

Med #3 __________________________________ Dosage ______________ Specific times taken each day _____________________

Reason for taking ____

Attach additional pages for more medications. Identify any medications taken during the school year that participant does/may not take during the summer: ____

Pali Institute Release

Child's name: ________________________ I have enrolled the afore-named child or children ('Child') in the program ('Program'). I understand the Child's participation in the Program involves exposure to inherent risks that cannot be eliminated. I also understand that the Child's participation in the Program may require the use of a ropes course and other Institute activities which have the potential risk of injury.

"Individually and as the parent or guardian of the Child, I HEREBY EXPRESSLY ASSUME ALL RISKS associated with the Child's participation in the Program including all risks associated with ropes courses and other Institute activities."

"Despite my understanding of the foregoing risks, I, individually and as the parent or legal guardian of the Child, AGREE NOT TO SUE AND TO RELEASE FROM LIABILITY AND TO DEFEND, INDEMNIFY AND HOLD HARMLESS PALI MOUNTAIN INSTITUTE, and their representatives, owners, employees and agents for any damage or injury arising out of the Child's participation in the Program regardless of the cause, including NEGLIGENCE."

"I understand that the foregoing is a LIABILITY RELEASE and a MEDICAL AUTHORIZATION that is legally binding on me, the Child, our heirs and our legal representatives and I sign it of my own free will. I acknowledge that the foregoing is binding during the 2011-2012 school season."

Signature of Parent/Legal Guardian ______________________________________ Date ________________________________