



TAMC

Health History and Examination Form

The information on this form is gathered to assist us in identifying appropriate care for TAMC delegates. Health History (the first three pages) must be filled out by parents/guardians of minors or by adults themselves. Update is required annually. Health Exam (back page) must be completed by an approved licensed medical personnel at least every two years.

E-mail these forms to the address below by **Friday, July 19, 2024**:

Major Sheila Gage
Sheila.Gage@use.salvationarmy.org

Name _____ Birth Date _____ Age at TAMC _____
Last First Middle

Address _____
Street City State Zip

Gender: Male Female

Parent/Guardian Name _____ Phone _____

Address _____
(if different from above) Street City State Zip

Second Parent/Guardian Name _____ Phone _____

Emergency Contact *(not Parent/Guardian)*

Name _____ Phone _____

Relationship to Participant _____

Address _____
Street City State Zip

Eastern Territory Salvation Army Camp

Has this participant attended an Eastern Territorial Salvation Army camp this summer? Yes No

If yes, please indicate which camp: _____

Parent/Guardian Authorizations: I hereby give permission for TAM Conservatory leadership to contact and collect medical records from other Eastern Territory Salvation Army Camps for medical treatment, referral, billing, or insurance purposes.

Signature of Parent/Guardian or adult participant _____ Date _____

Printed Name _____

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____



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

Important - These boxes must be complete for attendance*

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all TAMC activities except as noted. I hereby give permission to TAMC leadership to provide routine healthcare, 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 treatment, referral, billing, or insurance purposes. I give permission to TAMC leadership to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by TAMC leadership to secure and administer treatment, including hospitalization, for the person named above. This completed form may be copied for trips out of TAM Conservatory.

Signature of Parent/Guardian or adult participant _____ Date _____

Printed Name _____

I also understand and agree to abide by any restrictions placed on my participation in TAMC activities.

Signature of minor or adult camper _____ Date _____

Health History

The following information must be filled in by the parent/guardian or adult TAMC delegate. The intent of this information is to provide TAMC health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to TAMC health personnel upon participant's arrival at TAMC. Provide complete information so that TAMC leadership can be aware of your needs.

ALLERGIES List all known _____ Describe reaction and management of the reaction

Medication Allergies (list)

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Food Allergies (list) _____ Describe reaction and management of the reaction

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |

Other Allergies (list) _____ Includes insect stings, hay fever, asthma, animal dander, etc.

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at TAM Conservatory. 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 individual does NOT take medication on a routine basis

This individual takes medications 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 the participant does/may not take during the summer:

RESTRICTIONS

The following restrictions apply to this individual:

Dietary

Does not eat meat Does not eat seafood Does not eat dairy

Other (describe) _____

Explain any restrictions to physical activity (e.g. what cannot be done, what adaptations or limitations are necessary)

General Questions (explain "yes" answers below)

| Has/does the participant: | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Had any recent injury, illness or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Ever had problems with joints (e.g. knees, ankles)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Ever brought an orthodontic appliance to camp?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have any skin problems (e.g. itching, rash, acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had mononucleosis in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Had problems with diarrhea/constipation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have problems with sleepwalking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | 25. If female, have an abnormal menstrual history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have a history of bed-wetting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had seizures? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Ever had emotional difficulties for which professional help | | |
| 13. Ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | was sought? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 15. Ever been diagnosed with a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 16. Ever had back problems? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Please explain any "yes" answers, noting the number of the questions.

Which of the following has the participant had?

- Measels
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test
 Date of last test: _____
 Result: Positive Negative

Please give all dates of immunizations for:

| Vaccine: | Dates: | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr |
|-------------------------|--------|-------|-------|-------|-------|-------|-------|
| DTP | | _____ | _____ | _____ | _____ | _____ | _____ |
| TD (tetanus/diphtheria) | | _____ | _____ | _____ | _____ | _____ | _____ |
| Tetanus | | _____ | _____ | _____ | _____ | _____ | _____ |
| Polio | | _____ | _____ | _____ | _____ | _____ | _____ |
| MMR | | _____ | _____ | | | | |
| or Measles | | _____ | _____ | | | | |
| or Mumps | | _____ | _____ | | | | |
| or Rubella | | _____ | _____ | | | | |
| Haemophilus influenza B | | _____ | _____ | _____ | _____ | | |
| Hepatitis B | | _____ | _____ | _____ | | | |
| Varicella (chicken pox) | | _____ | _____ | | | | |

Use this space to provide any additional information about the participant's behavior (physical, emotional, or mental health) that TAM Conservatory leadership should be aware of.

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Healthcare Recommendations by Licensed Medical Personnel

I examined this individual on _____. (ACA accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program.

This applicant is under the care of a physician for the following conditions:

Recommendations and Restrictions at Camp

Treatment to be continued at TAMC

Medications to be administered at TAMC (name, dosage, frequency)

Any medically-prescribed meal plan or dietary restrictions?

Description of any limitation or restriction on TAM Conservatory activities

Known allergies

Additional information for health care staff at TAM Conservatory

| | |
|--|-------------|
| Signature of Licensed Medical Personnel _____ | |
| Printed _____ | Title _____ |
| Address _____ | |
| Phone _____ | Date _____ |

Parent/Guardian Authorizations: I agree and give permission for TAM Conservatory leadership to share and access the information listed in this medical examination to other TAMC and SLMC staff and leadership members, as it relates to the child's care and consideration during the week of TAM Conservatory and Star Lake Musiccamp (if the delegate indicates their attendance at Star Lake Musiccamp).

Signature of Parent/Guardian or adult participant _____ Date _____

Printed Name _____