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.

TAMC

Scan the QR code to submit health forms by: **Friday, July 18, 2025**:

Please contact kendacy.barnes@use.salvationarmy.org if you have any questions.

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
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐
16. Ever had back problems?	☐	☐
17. Ever had problems with joints (e.g. knees, ankles)?	☐	☐
18. Ever brought an orthodontic appliance to camp?	☐	☐
19. Have any skin problems (e.g. itching, rash, acne)?	☐	☐
20. Have diabetes?	☐	☐
21. Have asthma?	☐	☐
22. Had mononucleosis in the past 12 months?	☐	☐
23. Had problems with diarrhea/constipation?	☐	☐
24. Have problems with sleepwalking?	☐	☐
25. If female, have an abnormal menstrual history?	☐	☐
26. Have a history of bed-wetting?	☐	☐
27. Ever had an eating disorder?	☐	☐
28. Ever had emotional difficulties for which professional help was sought?	☐	☐

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 Musicamp (if the delegate indicates their attendance at Star Lake Musicamp).

Signature of Parent/Guardian or adult participant _____ Date _____

Printed Name _____