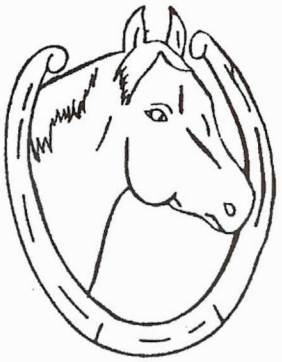

VALLEY VIEW RANCH

A Private Equestrian Summer Camp For Girls

606 Valley View Ranch Road
Cloudland, Georgia 30731
(706) 862-2231
Fax 706-862-6190

Cabin:_____
Session: _____
Year: _____
OFFICE USE ONLY:

HEALTH FORM

Name _____

Her Date of Birth _____ Camptime Age _____ Height_____ Weight _____

MOTHER'S NAME _____ OCCUPATION _____ COMPANY _____
FATHER'S NAME _____ OCCUPATION _____ COMPANY _____
ADDRESS _____ HOME PHONE _____
CITY_____ STATE_____ ZIP_____ CELL PHONE_____
E-MAIL_____ FAX NUMBER _____ BUSINESS PHONE _____

In An Emergency, Please Notify: _____Relationship:_____Phone: (____) _____
If not available in an emergency, notify _____ Relationship: _____Phone: (____) _____
Name of Family Physician and/or Health Care Clinic: _____ Phone: (____) _____
Name of Dentist/Orthodontist: _____ Phone: (____) _____
Name of Ophthalmologist/Optometrist: _____ Phone: (____) _____
Name and Date of last Physical Examination by a Physician: _____ Date_____

Do you carry family medical/hospital insurance? If so, indicate: Carrier: _____ Policy or Group No.:_____
INSURANCE: You are responsible for health and accident insurance and will supply a copy of your insurance card to Valley View Ranch.

ALLERGIES:
____ Asthma
____ Hay Fever
____ Ivy Poisoning
____ Insect Stings
_____ Sever (stop breathing)
_____ Mild (swollen/rash)
_____Other: _____
Foods: _____
Drugs: _____

Operations or serious injuries (dates): _____

Chronic or recurring illness or medical condition: _____

Dietary Restrictions: _____

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

IMPORTANT – MUST BE COMPLETED FOR ATTENDANCE

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications, including prescription drugs; to seek emergency medical treatment; order X-rays; routine tests, treatment, to release any records necessary for insurance purposes, and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp, or faxed if necessary. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

_____ **Date:** _____
Signature Of Parent or Guardian Or Adult Staff:

Witness: _____ Date: _____

I also understand and agree to abide by the restrictions placed on my camp activities as indicated in this health form.

Camper or Staff Signature: _____**Date:** _____

Health History

For Parent to fill out

Give dates and full details below for any "Yes" Answers.

IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF)
Attach more information if needed

	Yes	No	Year		Yes	No	Year
1. Serious Illness	___	___	____	17. Eyes/Ears	___	___	____
2. Serious Injury	___	___	____	18. Hearing impaired	___	___	____
3. Deformity	___	___	____	19. Hypertension	___	___	____
4. Surgery	___	___	____	20. Convulsions	___	___	____
5. Skin Glands	___	___	____	21. Epilepsy	___	___	____
6. Nose Sinusitis	___	___	____	22. Constipation	___	___	____
7. Heart	___	___	____	23. Athlete's Foot	___	___	____
- Murmur	___	___	____	24. Panic Attacks	___	___	____
- Rheumatic Fever	___	___	____	25. Bronchitis	___	___	____
8. Chest, Lungs	___	___	____	26. Fainting	___	___	____
9. Stomach, bowels	___	___	____	27.Depression	___	___	____
10. Appendicitis	___	___	____	28. Sore Throats	___	___	____
11. Kidneys or urine	___	___	____	29. Bleeding/Clotting	___	___	____
- Albumin	___	___	____	30. Mononucleosis	___	___	____
- Sugar	___	___	____	31. Sprains or breaks	___	___	____
- Infection	___	___	____	32. Chicken Pox	___	___	____
- Bed-wetting	___	___	____	33. Measles	___	___	____
12. Menstrual prob.	___	___	____	34. German Measles	___	___	____
13. Hernia	___	___	____	35. Mumps	___	___	____
14. Back,limbs,joints	___	___	____	36. Asthma	___	___	____
15. Sleepwalking	___	___	____	37. Tuberculosis	___	___	____
16. Nervous Cond.	___	___	____	38. Other(explain)	___	___	____

39. Are you aware of any current health problem ___Yes ___No
40. Now under medical care or taking medicines? ___Yes ___No
41. Has there been any surgery, injury, illness, allergy, or change in health status since last complete physical examination? ___Yes ___No

CONDITION OF: Eyes _____ Glasses _____ Contacts _____
What procedures should be taken if lost or broken at camp? _____

CONDITION OF: Teeth _____ Braces _____ Retainer _____
What procedures should be taken if lost or broken at camp? _____

For Girls: has this person Menstruated? ____ If not, has she been informed ?____
If so, is her menstrual history normal? _____

IMPORTANT: URGENT FOR THE WELL-BEING OF ENTIRE CAMP, MUST notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp.

IMMUNIZATION HISTORY

To be completed by Parent or Physician's Office

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) Tetanus or **DPT**	1. 2. 3.	1. 2.
Tetanus Diphteria or **TD**		
Tetanus		
Oral Polio (Sabin) **TOPV**		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubella)		
Mumps		
Rubella (German Measles, 3-day measles)		
Other		
Tuberculin test given _____ (most recent)		
Haemophilus influenza B (HIB)		
Hepatitis B		

PHYSICIAN'S HEALTH EXAM

ATTENTION PHYSICIAN: To attend Valley View Ranch, a health examination within the past 12 months is required.

The applicant will be participating in an active and sometimes strenuous activity schedule.

--Please insist applicant furnish complete medical history before exam.

--Please review immunizations for applicant to insure appropriate immunizations are current.

--Tetanus booster within last 10 years is required.

Check box if normal, circle if abnormal and give details below:

- ☐ Growth development
- ☐ Skin, glands, hair
- ☐ Head, neck, thyroid
- ☐ Ears
- ☐ Eyes
- ☐ Nose
- ☐ Teeth, tonsils
- ☐ Respiratory
- ☐ Cardiovascular
- ☐ Abdomen, hernia
- ☐ Skeletomuscular
- ☐ Neuropsychiatric
- ☐ Other(specify) _____
- ☐ Comments: _____

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 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 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 _____

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

PHYSICIAN'S EVALUATION AND ADVICE:

Date examined: _____
I have examined camp applicant within the past year. In my opinion the applicant 's condition _____ does _____ does not permit participation in an active camp program.
Specific restrictions/Recommendations: (explain other limitations or restrictions) _____

☐ ADDITIONAL INFORMATION IS ATTACHED.

Licensed Physician's Signature: _____

Address: _____ Phone:_____
Street & Number Area Code/Number

_____
City ST Zip

Date of Form Completion_____*By_____

*Initial if completed by nurse or physician's assistant

Applicant's
Height:_____ Weight:_____ Blood Pressure:_____/_____Pulse:_____
Hearing:___Normal ___Abnormal Vision:___Normal___Glasses___Contacts

Camper is under the care of a physician for following conditions:

Condition	Current Medication	To be continued at camp Specify dose or treatment
_____	_____	_____
_____	_____	_____

☐ Any condition that may require special care, medication, or diet:

___Asthma ___Convulsions ___Heart trouble ___Contact Lenses
___Diabetes ___ Epilepsy ___Fainting ___Bleeding Disorders
___Dentures ___Convulsions ___Concussion ___Loss of consciousness

☐ Circle Allergies to: drugs, foods, plants, animals, insects, chemicals:

☐ Indicate treatment to be administered._____