



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/Optomtrist: _____ 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: _____

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)

Foods: _____

Drugs: _____

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.

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

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.

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

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 Diphtheria 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:

- | | |
|---|---|
| <input type="checkbox"/> Growth development | <input type="checkbox"/> Teeth, tonsils |
| <input type="checkbox"/> Skin, glands, hair | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Head, neck, thyroid | <input type="checkbox"/> Cardiovascular |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Abdomen, hernia |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Skeletomuscular |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Neuropsychiatric |
| <input type="checkbox"/> Other(specify) _____ | |
| <input type="checkbox"/> Comments: _____ | |

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. _____