HEALTH HISTORY

Montecito Sequoia Family Camp Teen KILT Program

Complete this side PRIOR to Physician's Report

KILT Name____ Birthdate________________________ Age__________________

Address____ Zip Code_____________

In case of EMERGENCY notify: ____ Cell Phone: _____________________________

Address____ Alternate Phone: _________________________

Health/Accident Insurance with: ____ Policy No. ______________________________

ILLNESSES: Please check and note approximate age if teen has previously had any of the following:

❒ Chicken Pox______ ❒ Measles (2 wk)______ ❒ Rheumatic Fever______ ❒ Measles (3 day)______ ❒ Polio______ ❒ Mumps______

❒ Pneumonia____ ❒ **Covid**____(most recent diagnosis date: / /) ❒ Frequent Colds______ ❒Other____________________________

OPERATIONS AND TRAUMA:

Operations & Fractures: Type___________________________ Date ______________; Type________________________ Date___________

Comments: ____

MEDICAL CONDITIONS CAMP DOCTOR/NURSE/FIRST RESPONDERS SHOULD BE AWARE OF (check all that apply):

❒ Allergies: ____

❒ Chronic colds ❒ Athlete's Foot ❒ Epilepsy ❒ Diabetes ❒ Headaches ❒ Drug/Alcohol Abuse

❒ Menstrual irregularities ❒Other ____

❒ Any reaction to high altitude? If Yes, Explain:

❒ Has teen been exposed to or had any infectious diseases within the past four weeks? If YES, please specify:

MENTAL HEALTH CONCERNS/CONDITIONS: Has your teen ever consulted with or been treated by a physician, psychiatrist, or psychologist regarding a mental health concern? Or, as a parent/guardian, is there a mental health condition/concern or trait that the camp medical staff should be aware of? Such as:

❒ Anxiety ❒ Depression ❒ ADHD ❒ Disordered Eating ❒ Other: ______________________________________

❒ If Yes, Please explain:

ANY OTHER COMMENTS REGARDING YOUR TEEN'S HEALTH / MEDICATIONS (Attach separate sheet if needed):

In signing this form, permission is hereby given to the Camp Director at Montecito Sequoia to handle emergencies in terms of their own best judgment, and authorizes hospitalization and medical care as deemed necessary. It is also understood that the camp will utilize Health and Accident Insurance, where applicable, to cover medical expenses should they occur.

____ **Date**____

Signature of Parent/Guardian

NOTE: Other side of this form needs to be completed by a licensed M.D. or N.P.

Patient's **Name:**______________________________________ Patient's DOB_________________________

PHYSICIAN'S REPORT

NOTE TO PARENT/GUARDIAN of TEEN KILT: This portion of the report is to be completed by a Physician or NP prior to arrival at camp, OR please provide this information from a previous physical exam completed recently.

Montecito Sequoia Family Camp is in a remote wilderness area at an elevation of 7400' above sea level. The information below is required to provide safe and proper health treatment for our teen KILTs, if needed, during their time with us.

The purpose of this report is to ascertain whether this teen:

1. **Is in good health and can engage in strenuous activity between 7,400' – 8,200' above sea level**
2. **Has a communicable disease that could be conveyed to others**
3. **Has a medical, physical or mental health condition that needs special attention from our camp doctor/nurse/medical mgmt team**
4. **Has special dietary requirements, prescription medications, or limiting physical conditions of which the camp should be aware**

Does this teen (KILT) have any significant:

No **Yes**
❐ ❐ Medical Conditions?: ____
(List condition and any Rx Medications that will be used at camp)

No **Yes**
❐ ❐ Physical Conditions?: ____
(List back, stomach, lung, menstrual issues, etc.)

No **Yes**
❐ ❐ Mental Health Conditions?: ____
(List condition and any Rx Medications/treatments that will be used at camp)

No **Yes**
❐ ❐ Communicable Disease?: ____
(Recent exposure, if any, and if teen is cleared to return to normal activities/social interactions)

No **Yes**
❐ ❐ Allergic Conditions?: ____
(List allergies and any allergy Rx or OTC medications/treatment that will be used at camp)

If more space is needed, please continue below or attach an additional sheet of paper:

List past serious injuries or illnesses (Broken bones, Rheumatic Fever, Pneumonia, Concussions, etc. - see reverse side of form):

No **Yes**
❐ ❐ Does this teen have any Prescription medication(s) to be taken while at camp? If Yes, describe_______________________

Medicine/Dosage______________________________ Medicine/Dosage________________________________
Medicine/Dosage________________________________

Are **IMMUNIZATIONS** current?

No **Yes**
❐ ❐ Polio

No **Yes**
❐ ❐ Measles

No **Yes**
❐ ❐ Tetanus (Date of last tetanus booster/Tdap: / /)

No **Yes**
❐ ❐ **Covid-19** (Primary Series)

No **Yes**
❐ ❐ Covid-19 Booster Dose(s)

Covid Fall '23/Winter '24 Vaccine? **N / Y**

Has this teen had Covid in the past year? No ❐ **Yes** ❐ If yes, date(s) of illness:_______________ **Has teen fully recovered from Covid?** **N / Y**

Are you this teen's/patient's regular physician? No ❐ **Yes** ❐ Blood type, if known_____________________________

GENERAL/ADDITIONAL COMMENTS:

Physician's Name (Print)____ **Phone (**_______**)**______________________

Address____ **City/Zip**___________________________

Physician's Signature____ **Date**___________________________