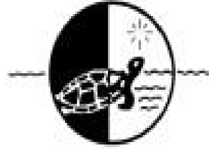
TURTLE CAMP



AQUATECH DIVE CENTER AND HOTEL
VILLAS DEROSA RESORT
AKUMAL

Health History and Contact Information
Please email completed form to:

cenotes@prodigy.net.mx

Name ____
Birth date ______________ Age at camp______
Home address
____
____
Social security number of participant ____________________________________
Gender: ______Male ______ Female

Parent/Legal guardian ____
Phone ____________________________
Email____________________________
Home address
____
____
Second parent/ legal guardian ____
Phone____________________________
Email____________________________
Home address
____
____
In case of an emergency please notify:
Name____
Relationship ________________________
Phone _____________________________
Email______________________________

Insurance Information
Is the participant covered by family medical/hospital insurance? ____ Yes____No
If so, indicate company/ carrier name
____ Group#_______________

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

ALLERGIES List all known. Describe reaction and management of the reaction.
Medication allergies____
Food allergies____
Other allergies____

MEDICATIONS BEING TAKEN
______ This person takes NO medications on a routine basis.

Please list ALL medications taken routinely. Keep it in the original packaging / bottle that indicate the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

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 participant does/may not take during the summer:
____
____
____

Description of any limitation or restriction on camp activities
Additional information for health care staff at the camp

Dietary
_ Does not eat red meat _ Does not eat pork _ Does not eat eggs
_ Does not eat poultry _ Does not eat seafood _ Does not eat dairy products
_ Other (describe)
____
____

Recommendations and Restrictions at Camp
Treatment to be continued at camp

RESTRICTIONS
The following restrictions apply to this individual. Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are

Health History
The following information must be filled in by the parent/ legal guardian. The intent of this information is to provide camp personnel the adequate information to provide appropriate care. Please keep a copy of the completed form for your records. Any changes to this form should be provided to camp personnel.

Please check all that apply
Which of the following has the participant had?
___Measles
___Chicken pox
___ German measles
___ Mumps
TB/ Mantoux test
Date of last test _______________
Result: _ Positive _ Negative
Other_______________________

Use this space to provide any additional information about the participant's behavior (physical, emotional, or mental health) which the camp should be aware.
____
____
Name of family physician ____
Phone__________________________
Email___________________________

Past Medical History
Has or does the participant experience the following (PLEASE CIRCLE ONE):

Recent injury, illness or infectious disease YES/NO
Chronic or recurring illness/condition YES/NO
Frequent headaches YES/NO

Head injury YES/NO
Passed out/dizzy during or after exercise YES/NO
Chest pain during or after exercise YES/NO
High blood pressure YES/NO
Seizures YES/NO
Diagnosed with a heart murmur YES/NO
Back problems YES/NO
Skin problems (e.g., itching, rash, etc.) YES/NO
Diabetes YES/NO
Asthma YES/NO
Problems with diarrhea/constipation YES/NO
Problems with sleepwalking YES/NO
Emotional difficulties for which professional help was sought YES/NO

Health Care 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.
The applicant is under the care of a physician for the following conditions

Signature of Licensed Medical Personnel

____

Printed ______________________________ Title______________________________

____

Address ____

Phone ____ Date ______________

Screening Record

Date screened ____ Time ______________

Meds received

____

Updates/additions to health history noted _ Yes _ No _ None required

Current health needs identified ____

Observational notes

____

Screened by ____

For Office Use
I also understand and agree to abide by any restrictions placed on my participation in camp activities.
Signature of minor or adult camper/staffer ______________________________ Date ______________

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 camp activities except as noted. I hereby give permission to the camp to provide routine health care, 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 the camp 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 the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staffer ______________________________________

Printed Name ____ Date ______________

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians of minors or by adults themselves. Update required annually. Health exam (back page) must be completed by approved licensed medical personnel at least every two years.