

Camper Health History Form

Dates will attend camp: From _____ to _____
month/day Month/Day

Camper Name: _____
First Middle Last

Birth date: ____/____/____ Age on arrival at camp: _____

To Parent(s)/Guardians: Please follow the instructions below. Attach additional information if needed.

1. Complete pages 1, 2 and 3 of this form and make a copy.
2. **Take the original, signed forms (pages 1-4) with you to camp.**
3. Complete the top portion of the Camper Health-Care Recommendations form and give to your child's health-care provider for review and completion.
4. After it has been completed and signed by your child's health-care provider, **bring the form with you to camp.**

Camper Home Address: _____
Street Address City State Zip Code

Parent/Guardian with Legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to camper: _____

Home Address: _____

Preferred Phone (____) ____-____ Email: _____

Second Parent/Guardian or other emergency contact:

Name: _____ Relationship to camper: _____

Preferred Phone (____) ____-____ Email: _____

Additional contact in event parent/guardian can not be reached:

Name: _____ Relationship: _____ Preferred Phone (____) ____-____

Allergies: No Known Allergies This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc)
 Other (Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: This camper eats a regular diet This camper eats a regular vegetarian diet
 This camper has special food needs. (please describe below)

Restrictions: I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. (please describe below)

Medical Insurance Information:

This camper is covered by family medical/hospital insurance Yes No

Insurance Company: _____ Policy Number: _____

Subscriber: _____ Insurance Company Phone Number: (____) ____-____

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Parent/Guardian: _____ Date: _____

Relation to camper: _____

Camper's Name _____

(For Camp Use) Cabin or Group _____

(For Camp Use) Session Code: _____

Camper Name: _____ Birth Date: ____/____/____
First Middle Last Month/Day/Year

Immunization History: Provide the month and year for each immunization. * immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable: please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, Tetanus, Pertussis * (Dtap or Tdap)						
Tetanus booster * (dT or Tdap)						
Mumps, measles, rubella * (MMR)						
Polio * (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
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If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of parent/guardian: _____ Date: _____ Relationship: _____

Medication This Camper will not take any daily medications while attending camp.
 This camper will take the following daily medication(s) while at camp:

“Medication” is any substance a person takes to maintain and/or improve health. This includes vitamins and natural remedies. All creams and medicines are turned in to the Health Supervisor on opening day. All medication must be in its original container labeled with contents, directions for administering and camper’s full name. These will be kept by the Health Supervisor in a locked cabinet for the duration of resident camp. Please provide enough medication to last the entire length of camp.

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How is it given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

The following non-prescription medications may be stocked in the camp health center and are used on an as needed basis to manage illness and injury. **Cross out those the camper should not be given.**

- | | |
|---|-------------------------------------|
| Antihistamine/allergy medication | Sore throat spray |
| Dextromethorphan cough syrup (Robitussin DM) | Calamine lotion |
| Guaifenesin cough syrup (Robitussin) | Aloe |
| Lice shampoo or cream (Nix or Elimite) | Antibiotic Cream |
| Phenylephrine decongestant (Sudafed PE) | Generic cough drops |
| Pseudoephedrine decongestant (Sudafed) | Acetaminophen (Tylenol) |
| Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) | Ibuprofen (Advil, Motrin) |
| Diphenhydramine antihistamine/allergy medication (Benadryl) | Laxatives for constipation (Ex-Lax) |

Camper Name: _____ Birth Date: ____/____/____
First Middle Last Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

- | | | | |
|-------------------------------------|--|---|--|
| 1. Ever been hospitalized? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had asthma/wheezing/shortness of breath? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illness? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis (mono) during the past 12 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Have problems with periods/menstruation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had fainting or dizziness? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. have problems with diarrhea/constipation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Wear glasses/contacts/protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Have any skin problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name the countries visited and the dates of travel.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the Camper:

- | | |
|---|--|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect the camper's life? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health Care Providers:

Name of camper's primary care doctor: _____ Phone: (____) _____ - _____

Name of Dentist: _____ Phone: (____) _____ - _____

Name of orthodontist: _____ Phone: (____) _____ - _____

What have we forgotten to ask? Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.

Parents/guardians: STOP HERE.

Camper Health-Care Recommendations by Licensed Medical Personnel Form

Dates will attend camp: From _____ to _____ Age on arrival at camp: _____
month/day Month/Day

Camper Name: _____ Birth date: ____/____/____
First Middle Last

Home address: _____

Parent/Guardian phone: (_____) _____ - _____

The following non prescription medicines are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. **Medical Personnel: Cross out those items the camper should not be given.**

- Acetaminophen (Tylenol)
- Aloe
- Antibiotic Cream
- Antihistamine/allergy medication
- Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)
- Calamine lotion
- Dextromethorphan cough syrup (Robitussin DM)
- Diphenhydramine antihistamine/allergy medication (Benadryl)
- Generic cough drops
- Guaifenesin cough syrup (Robitussin)
- Ibuprofen (Advil, Motrin)
- Laxatives for constipation (Ex-Lax)
- Lice shampoo or cream (Nix or Elimite)
- Phenylephrine decongestant (Sudafed PE)
- Pseudoephedrine decongestant (Sudafed)
- Sore throat spray

Medical Personnel: Please complete the remaining sections of this form. Attach additional information if needed.

Physical Exam done today: Yes No (If "No", date of last physical: _____)

Physical exam must be within the last 24 months.

Weight: _____ lbs Height _____ ft _____ in Blood Pressure _____ / _____

Allergies: No known allergies

To Foods (list):

To medications (list):

To the environment (insect stings, hay fever, etc. list):

Other allergies (list):

Describe previous reactions:

Diet, Nutrition: Eats a regular diet Has a medically prescribed meal plan or dietary restrictions: (describe below)

The camper is undergoing treatment at this time for the following conditions: (describe below) None

Medication: No daily medications will take the following prescribed medications while at camp:
 (name, dose, frequency - describe below)

Other treatment/therapies to be continued at camp: (describe below) None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? no yes
 If you answered "yes" to the question above, what do you recommend? (describe below)

I have reviewed the Camper Health History Form and have discussed the camp program with the camper's parent/guardian. It is my option that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider(please print): _____

Signature: _____ Title: _____

Office address: _____

Office phone: (_____) _____ - _____ Date: ____/____/____