CAMPER HEALTH HISTORY FORM 1

Mail by_____

Dates will attend camp: from_____ to _____
Month/Day/Year Month/Day/Year

Camper Name:_____
First Middle Last

___Male ___Female Birth Date _____
Month/Day/Year

INSTRUCTIONS FOR PARENT/GUARDIAN
ATTACH ADDITIONAL INFORMATION IF NEEDED

1) Complete and make a copy
2) Send the original, signed Form 1 to camp by the requested date
3) Complete the top of the Health Care Provider Form 2 and provide a copy of Form 1 along with Form 2 to your child's Health Care Provider for review and completion.
4) After having Form 2 completed and signed by your child's health care provider, return Form 2 to camp by the requested date.

Camper Home Address_____
Street City State Zip

Parent/guardian with legal custody to be contacted in case of illness or injury

Name:_____ Relationship _____Phone_____
To Camper

Email_____

Home Address: _____
Street City State Zip

Second/parent/guardian or other emergency contact:

Name _____ Relationship _____ Phone _____
To Camper Email_____

CAMPER HEALTH HISTORY FORM 2

ALLERGIES: Check One _____ No Known Allergies

_____ Yes Allergic to

_____ Food _____ Medicine _____ Environment (Insects, Hay fever, etc)

Describe allergies to and reactions seen:_____

_____

_____

_____

Diet/Nutrition: Check one

____ Camper eats regular diet _____ Camper eats vegetarian diet ____ Camper needs special foods (explain below)

_____

_____

Restrictions:

___ I have reviewed the program and activities of the camp and feel the camper can participate without restriction.

___ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions. (Please explain below)

_____

_____

_____

CAMPER HEALTH HISTORY FORM 3

Medical Insurance Information:

Is camper covered by family medical/hospital insurance ___ Yes ____ No
(Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.)

Insurance Company: _____ *Policy Number* _____

Subscriber: _____ *Insurance Company Phone #*_____

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 injections, 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 photo copy 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 _____ Date_____
Parent/
Guardian _____
Relationship to Camper

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.

_____ Date _____
Signature
Relationship to Camper _____

CAMPER HEALTH HISTORY FORM 4

Medication:

The camper will not take any medication while attending camp _____
The camper will take the following daily medications while camping _____

This includes vitamins and Natural remedies.

Please review camp instructions about required packaging/containers. Provide enough of each medication to last the entire time the camper will be at camp.

Name of Medication	Date Started	Reason for taking it	When it is given	Amount or dose given	How it is given
			__Breakfast __ Lunch __ Dinner __ Bedtime __ Other		
			__Breakfast __ Lunch __Dinner __ Bedtime __ Other		
			__Breakfast __ Lunch __ Dinner __Bedtime __Other		

CAMPER HEALTH HISTORY FORM 5

The following non prescription medications will 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.

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

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

Has/does the camper:

1. Ever been hospitalized ? ___Yes ___ No
2. Ever had surgery? ___ Yes ___ No
3. Have recurrent/chronic illnesses? ___ Yes ___ No
4. Had a recent infectious disease? ___ Yes ___ No
5. Had a recent injury? ___ Yes ___ No
6. Had asthma/wheezing/shortness of breath? ___ Yes ___ No
7. Have diabetes? ___ Yes ___ No
8. Had seizures? ___ Yes ___ No
9. Had headaches? ___ Yes ___ No
10. Wear glasses, contacts, or Protective eyewear? ___ Yes ___ No
11. Had fainting or dizziness? ___ Yes ___ No
12. Passed out/had chest pain during exercise? ___ Yes ___ No
13. Had Mononucleosis (“mono”) during the Past 12 months? ___ Yes ___ No
14. If female, have problems with periods Menstruation? ___ Yes ___ No
15. Have problems with falling asleep/ Sleep walking? ___ Yes ___ No

CAMPER HEALTH HISTORY FORM 6

16. Ever had back/joint problems? ___ Yes ___ No
17. Have a history of bedwetting? ___ Yes ___ No
18. Have problems with diarrhea/constipation? ___ Yes ___ No
19. Have any skin problems? ___ Yes ___ No.
20. Traveled outside of the country in the Past 12 months? Where? ___ Yes ___ No

Please explain "Yes" answers in the space below, noting the number of the questions.

_____
_____
_____
_____

1. Has the camper ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD) ___ Yes ___ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ___Yes ___ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ___ Yes ___ No
4. Had a significant life event that continues to affect the camper's life? ___ Yes ___ No

Please explain yes answers below.

_____
_____
_____
_____

Health Care Providers:

1. Name of Camper's primary doctor: _____Phone#_____
2. Name of Dentist _____ Phone# _____
3. Name of orthodontist: _____Phone#_____

ADDITIONAL INFORMATION WE SHOULD KNOW ABOUT THIS CAMPER:

_____
_____
_____
_____
_____
_____
_____
_____

Parents/Guardians: <u>STOP</u> here. ***The rest of this form is completed when the camper arrives at the camp. Keep a copy for your records.***

CAMPER HEALTH HISTORY FORM 7

COMPLETED AT THE CAMP

Initial Screening Date/Time _____ Initials _____

_____ Screening has been conducted according to camp protocol and significant Findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival? ___ Yes ___ No
B. History of exposure to communicable disease? ___ Yes ___ No
C. Additions or corrections to information on this health history? ___ Yes ___ No
D. Medication given to health care staff? ___ Yes ___ No

Yes explained below:

_____
_____
_____
_____

Provider Notes: Date/Time/Initial all entries:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Exit Note: Check one of the following:

_____ Left camp this day with no reported illness or injury symptoms:

_____ Left camp this day with the following problem/concern:

_____
_____
_____

This person was told about the problem and instructed about the follow up as noted above: Date/Time _____ Initials _____