



**HEALTH HISTORY FOR CAMPERS**

The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. Health history must be filled out by parents/guardians of minors. Update required annually.

Name Last	First	M.I.	Birth Date	Age at Camp
Home Address			City	State Zip
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female				
Custodial Parent / Guardian			Home Phone	Cell Phone
Home Address (If different from above)			City	State Zip
Business Address		City	State Zip	Phone
Second Parent / Guardian or Additional Emergency Contact				Relationship
Preferred Phone(s)				
If you were unable to be reached in an emergency would you allow your camper to be sent home with the emergency contact person? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Insurance Information: Is camper covered by medical / hospital insurance?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Carrier or Plan Name			Group #	
Subscriber			Insurance Phone / Contact Number	
Please enclose a copy of your Insurance Card (REQUIRED) <input type="checkbox"/> Done				

**Important – This box must be completed for attendance**

If completing form online, print form and sign in ink below.

This health history is correct and complete as far as I know. The person named herein has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medication, and emergency treatment for myself or my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treat as acting *in loco parentis* if the above named person is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representative" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event that 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**

\_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

I also understand and agree to abide by any restriction placed on my participation in camp activities.

Signature of Camper \_\_\_\_\_ Date \_\_\_\_\_

Name of Camper's Doctor	Phone
Name of Camper's Dentist	Phone
Name of Camper's Orthodontist	Phone

## HEALTH HISTORY

The following information must be filled in by the parent / guardian. The intent of the information is to provide camp health care personnel the background to provide appropriate care. Provide complete information so that the camp can be aware of your needs. Any changes to this form should be provided to the camp health personnel upon the participant's arrival to camp.

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<b>ALLERGIES</b> (List all known)	<input type="checkbox"/> <b>No known allergies</b>
<b>Medication Allergies</b>	Describe reaction and management of reaction.
<b>Food Allergies</b>	Describe reaction and management of reaction.
<b>Other Allergies</b> (includes latex, insect stings, hay fever, asthma triggers, animal dander, etc.)	Describe reaction and management of reaction.

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### MEDICATIONS BEING TAKEN

Please list **ALL** medications (including over-the-counter or non-prescription drugs) taken routinely. "Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. 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 will take the following daily medications while at camp (Attach additional pages for more medications):

Medication #1	Date Started	When it is given	Amount or dose given	How it is given
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		

Reason for taking

Medication #2	Date Started	When it is given	Amount or dose given	How it is given
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		

Reason for taking

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.

**Check box or cross out those the camper should NOT be given.**

<input type="checkbox"/> Acetaminophen (Tylenol)	<input type="checkbox"/> Ibuprofen (Advil, Motrin)	<input type="checkbox"/> Antihistamine/Allergy medicine (Claritin, Zyrtec)	
<input type="checkbox"/> Diphenhydramine/allergy medicine (Benadryl)	<input type="checkbox"/> Sore throat spray	<input type="checkbox"/> Generic cough drops	<input type="checkbox"/> Antibiotic cream
<input type="checkbox"/> Calamine lotion	<input type="checkbox"/> Aloe	<input type="checkbox"/> Loperimide (Immodium)	<input type="checkbox"/> TUMS

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### RESTRICTIONS (the following apply to this individual)

#### Dietary Restrictions

<input type="checkbox"/> Does not eat red meat	<input type="checkbox"/> Does not eat pork	<input type="checkbox"/> Does not eat eggs
<input type="checkbox"/> Does not eat poultry	<input type="checkbox"/> Does not eat seafood	<input type="checkbox"/> Does not eat dairy products
<input type="checkbox"/> Other (describe)		

#### Activity Restrictions

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### SLEEP ISSUES

This camper has no issues with sleeping at night.  
 This camper **HAS** issues with sleeping at night. If so, please explain:

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### MENTAL and EMOTIONAL HEALTH INFORMATION (Answer this section referencing the essential functions of your camp job)

- This camper has an emotional health concern that will impact camp participation.  Yes  No
- This camper has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder.  Yes  No
- This camper has been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD).  Yes  No
- This camper has been treated for emotional or behavioral difficulties or an eating disorder.  Yes  No
- This camper has/had a significant life event that continues to affect the camper's life/health.  Yes  No
- This camper uses an individualized learning plan at school.  Yes  No

If "Yes" was the answer to any of the six statements on the previous page, please attach a statement from your child's professional (e.g. physician, psychiatrist, therapist) that addresses the following with regard to your child's participation at camp.

- a. Describes the concern and the camper's management plan (including medications) while at camp;
- b. Describes the behaviors that will indicate to our staff that your camper needs professional referral; and
- c. Provides a recommendation from this professional supporting your child's participation in our camp program.

**GENERAL QUESTIONS** (explain "yes" answers below)

Has / does the camper:

1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Ever had chest pain after / during exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have a chronic or recurring illness / condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Ever had back or joint problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Ever been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Have any skin problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Ever had surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	16a. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Ever had a head injury or been knocked unconscious?	<input type="checkbox"/> Yes <input type="checkbox"/> No	16b. Wears braces?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Wear glasses, contacts, or protective eyewear?	<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Have asthma/wheezing/shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Had frequent ear infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Have issues with bed-wetting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Had fainting or dizziness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Had mononucleosis in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Had seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	21. If female, have problems with periods/menstruation	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have problems with diarrhea / constipation?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please explain any "Yes" answers below, noting the number of the questions (attach additional sheet of paper if necessary).

**IMMUNIZATION HISTORY**

Provide the month and year for each immunization. Starred (\*) immunizations must be current. Copies of immunization forms from healthcare providers or state or local government are acceptable, please attach to this form.

Immunization	Dose 1 Mo/Yr	Dose 2 Mo/Yr	Dose 3 Mo/Yr	Dose 4 Mo/Yr	Dose 5 Mo/Yr	Most recent dose Mo/Yr
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 A						
Hepatitis B						
Varicella (chicken pox) Had chicken pox, Date:						
Meningococcal meningitis (MCV4)						
<b>Tuberculosis (TB) test</b> Date: <input type="checkbox"/> Negative <input type="checkbox"/> Positive						

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 \_\_\_\_\_

**WHAT HAVE WE FORGOTTEN?**

Use this space to provide any additional information on the camper's behavior, physical, emotional, or mental health about which the camp should be aware.

## ARRIVAL SCREENING

The Arrival Screening is conducted according to camp protocol with these findings: **completed by Camp Nurse**

Date/Time:

Completed by:

- |  |                             |  |
|--|-----------------------------|--|
| 1. Any updates to the health history form?           | <input type="checkbox"/> No | <input type="checkbox"/> Yes, as noted below |
| 2. Any signs / symptoms of illness or injury?        | <input type="checkbox"/> No | <input type="checkbox"/> Yes, as noted below |
| 3. Any medications given to the health center staff? | <input type="checkbox"/> No | <input type="checkbox"/> Yes, as noted below |
| 4. Any special needs of this person while at camp?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes, as noted below |

## EXIT NOTES

Date/Time:

Completed by:

- Left camp this day with no reposted injury or illness signs / symptoms.
- Left camp this day with the following problem / concern:  
Person who was told about this problem / concern: \_\_\_\_\_
- Health care record closed. (Initial) \_\_\_\_\_

## NURSE'S NOTES OF CARE PROVIDED TO CAMPER DURING CAMP