RESIDENT CAMP AND 3+ DAY TRAVEL HEALTH HISTORY FORM

To Caregivers: Please follow the instructions below. Attach additional information if needed.

1. Complete pages 1 , 2 and 3 of this form.
2. Make a copy of completed forms for your own records, health forms will not be returned.
3. **Bring the form with you to camp**.

Camper Name:________________________________ **Birth Date:**____/____/____ **Age:** ______
First Middle Last Month/Day/Year

Caregiver with Legal custody to be contacted in case of illness or injury:

Name:______________________________________ Relationship to camper: ____________________

Home Address: ____

Preferred Phone (______)________--_________Email: ____

Second Caregiver or other emergency contact:

Name:______________________________________ Relationship to camper: ____________________

Preferred Phone (______)________--_________Email: ____

Additional contact in event Caregiver can not be reached:

Name:____________________________ Relationship:______________ Preferred Phone (_____)______--_____

Medical Insurance Information:

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

Insurance Company: ________________________ Policy Number: ____________________

Subscriber: ____________________________ Insurance Phone Number: (_______)_______-__________

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

Health Care Providers:

Name of 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.

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
Diptheria, Tetanus, Pertussis * (Dtap or TdaP)							
Tetanus booster * (dT or TdaP)							
Mumps, measles, rubella * (MMR)							
Polio * (IPV)							
Haemophilus influenza type B (HIB)							
Pneumococcal (PCV)							
Hepatitus B							
Hepatitus A							
Varicella (chicken pox)	☐ Had chicken pox Date:						
Meningococcal meningitis (MCV4)							
Coronavirus (COVID-19)							

Tuberculosis (TB) test	Date:	☐ Negative ☐ 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 Caregiver:_____________________________________Date:____________Relationship:____________

_______ My Camper has had a physical exam within the last 12 months (24 months for 3+ days travel). Date:________/________

Initial Month Year

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

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 any that your camper should not be given.**

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

Camper Name:____ Birth Date:____/____/______

First Middle Last Month/Day/Year

Allergies:	☐ Food ☐ Medicine ☐ Environmental ☐ Other ☐ No Know Allergies	Please describe what the camper is allergic to and the reaction seen.
Diet:	☐ This camper eats a regular diet ☐ This camper has special food needs. (please describe below)	☐ This camper eats a regular vegetarian diet
Restrictions:	☐ I have reviewed the program/activities of the camp and feel the camper can participate without restrictions. ☐ I have reviewed the program/activities of the camp and feel the camper can participate with the following restrictions or adaptations. (please describe below)	

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 illness? ☐ Yes ☐ No
4. Had a recent infectious disease? ☐ Yes ☐ No
5. Had a recent injury? ☐ Yes ☐ No
6. Had fainting or dizziness? ☐ Yes ☐ No
7. Have diabetes? ☐ Yes ☐ No
8. Had seizures? ☐ Yes ☐ No
9. Had headaches? ☐ Yes ☐ No
10. Have any skin problems? ☐ Yes ☐ No
11. Had asthma/wheezing/shortness of breath? ☐ Yes ☐ No
12. Passed out/had chest pain during exercise? ☐ Yes ☐ No
13. Had mononucleosis (mono) during the past 12 months? ☐ Yes ☐ No
14. Have problems with periods/menstruation? ☐ Yes ☐ No
15. Have problems with falling asleep/sleepwalking? ☐ Yes ☐ No
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. Wear glasses/contacts/protective eyewear? ☐ Yes ☐ No
20. Traveled outside the country in the past 9 months? ☐ Yes ☐ 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)? ☐ 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 in the space below, noting the number of the questions. The camp may contact you for additional information.

Caregiver 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. 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 Caregiver: ______________________________ Date:__________________________

Relation to camper: ________________________