Health History Form for Children, Youth & Adults Attending Camps 2021

Please fill out and complete the following form. This form is mandatory before participating in summer camp. **Return no later than one week prior to the first Day of Camp.**

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. Any changes to this form should be provided to camp health personnel upon participant s arrival in camp. Provide complete information so that the camp can be aware of your needs. Thank you.

Weeks Attending Camp: _____

Camper Name (Last) _____ (First) _____ (Gender) ___ Male ___ Female

Home Address _____ (City) _____ (State) _____ (Zip Code) _____

Parent/Guardian (Name) _____ (Phone) _____

Home Address (if different than child) _____

Business Address _____

Second Parent/Guardian (Name) _____ (Phone) _____

Home Address (if different than child) _____

Business Address _____

Emergency Contact if Not Available (Name) _____ (Phone) _____ (Relationship) _____

Insurance Information

Is the participant covered by family medical/hospital insurance? __ Yes __ No

If yes, indicate carrier or plan name _____ Group # _____

NOTICE - photocopy of front/back of health insurance card must be attached to this form.

IMPORTANT - The below must be complete and signed for camper attendance*

Parent/Guardian Authorization: This health history is correct and complete as far as I know, and 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 heath 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, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature Parent/Guardian _____(Name Printed)_____ (Date) _____

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

Signature of Minor Aged Camper _____ (Date) _____

**If for religious reasons you cannot sign this, contact the camp for a legal waiver, which must be signed for attendance.*

ALLERGIES List all known and describe reaction and management of the reaction.

Medication allergies (list) _____

_____

Food allergies (list) _____

_____

Other allergies (list) _____

_____

MEDICATIONS BEING TAKEN: Please list ALL medications (including over the counter or nonprescription drugs) taken routinely. 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.

Select One ___ This person takes NO medications on a routine basis, OR ___ This person takes medications as follows:

Medication #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Medication #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications if necessary.

Identify any medications taken during the school year that participant does/may not take during the summer:

_____

RESTRICTIONS (The following restrictions apply to this individual.)

Does not eat: ___Red Meat, __ Pork, __ Dairy Products, __Poultry, __ Seafood, __ Eggs, __ Other (describe) _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

GENERAL QUESTIONS (Explain "yes" answers below.)

Have you ever tested positive for COVID-19? Yes __ No___
If yes, when were you diagnosed? _____
If yes, how long have you been symptom free? _____ days.
Do you have an autoimmune disease or immunodeficiency disease? _____
Please note, we will not allow campers to come if they have not been symptom free for at least 10 days, this is per CDC updated guidelines.

Has/does the participant:

1. Had any recent injury, illness or infectious disease? __ Yes, __ No
2. Have a chronic or recurring illness/condition? __ Yes, __ No
3. Ever been hospitalized? __ Yes, __No
4. Ever had surgery? __ Yes, __ No
5. Have frequent headaches? __ Yes, __ No
6. Ever had a head injury? __ Yes, __ No
7. Ever been knocked unconscious? __ Yes, __ No
8. Wear glasses, contacts or protective eyewear? __ Yes, __ No
9. Ever had frequent ear infections? __ Yes, __ No
10. Ever passed out during or after exercise? __ Yes, __ No
11. Ever been dizzy during or after exercise? __ Yes, __ No
12. Ever had seizures? __ Yes, __ No
13. Ever had chest pain during or after exercise? __ Yes, __ No
14. Ever had high blood pressure? __ Yes, __ No
15. Ever been diagnosed with a heart murmur? __ Yes, __No
16. Ever had back problems __ Yes, __ No
17. Ever had problems with joints (e.g., knees, ankles)? __ Yes, __ No

18. Have an orthodontic appliance being brought to camp? __ Yes, __ No
19. Have any skin problems (e.g., itching, rash, acne)? __ Yes, __ No
20. Have diabetes? __ Yes, __ No
21. Have asthma? __ Yes, __ No
22. Had mononucleosis in the past 12 months? __ Yes, __ No
23. Had problems with diarrhea/constipation? Yes,__ No
24. Have problems with sleepwalking? __ Yes, __ No
25. If female, have an abnormal menstrual history? __ Yes, __ No
26. Have a history of bed-wetting? __ Yes, __ No
27. Ever had an eating disorder? __ Yes, __ No
28. Ever had emotional difficulties for which professional help was sought? __ Yes, __ No

Please explain any "yes" answers, noting the number of questions. _____

_____

_____

Which of the following has the participant had?

__Measles, __Chicken Pox, __German Measles, __Mumps, __Hepatitis A, __Hepatitis B, __Hepatitis C,

TB Mantoux Test, Date of last test _____ Result: __Positive, __Negative

Please give all dates of immunization for:

Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
1. DTP	_____	_____	_____	_____	_____	_____
2. TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
3. Tetanus	_____	_____	_____	_____	_____	_____
4. Polio	_____	_____	_____	_____	_____	_____
5. MMR	_____	_____	_____	_____	_____	_____
a. or Measles	_____	_____	_____	_____	_____	_____
b. or Mumps	_____	_____	_____	_____	_____	_____
c. or Rubella	_____	_____	_____	_____	_____	_____
6. Haemophilus Influenza B	_____	_____	_____	_____	_____	_____
7. Hepatitis B	_____	_____	_____	_____	_____	_____
8. Varicella (chicken pox)	_____	_____	_____	_____	_____	_____

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

_____

Name of physician _____ Address _____ Phone _____

Physician s Signature _____ Date _____

Name of dentist _____ Address _____ Phone _____

THANK YOU

(FOR CAMP USE ONLY)

Screened by: _____, Date Screened _____ Time _____ am/pm, Updates noted __ Yes, __ No, __ NA

Meds Received _____, Current health needs identified _____

_____

Observation notes _____

_____