CAMPER MEDICAL FORM

This form must be completed in full and include a copy of both sides of your insurance card and a current immunization record for your camper. This form must be completed in addition to the Camper Physical Form.

Camper Name: _____ Date of Birth_____Grade:_____

Camper Home Address: _____
Street Address City State Zip Code

Camp Session(s) Attenting: _____

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

Name: _____ Relationship to Camper: _____Preferred Phones: (_____) _____(_____)_____

Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____Preferred Phones: (_____) _____(_____)_____

Email: _____

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

Name(s): _____ Relationship to Camper: _____ Preferred Phones: (_____) _____(_____)_____

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

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

Policy Holder's Name_____

Insurance Company_____ Policy Number_____

Subscriber_____ Insurance Company Phone Number (_____) _____

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 Custodial Parent/Guardian _____Date: _____ Relationship to Camper: _____

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

CAMPER MEDICAL FORM

IMMUNIZATION HISTORY

ATTACH COPY OF CURRENT IMMUNIZATION RECORD TO THIS PACKET

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 Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

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 their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. 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 time:_		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐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.***

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

****Please continue to next page**

CAMPER MEDICAL FORM

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/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. Have any skin problems? ☐ 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 countries visited and 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 (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
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

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 doctor(s): _____ Phone: (_____) _____

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ 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. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

CAMPER MEDICAL FORM

Individual Health Record (For Camp Use Only)

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?..... ☐ No ☐ Yes as noted below

B. History of exposure to communicable disease?..... ☐ No ☐ Yes as noted below

C. Additions or corrections to information on this health history?..... ☐ No ☐ Yes as noted below

D. Medication given to health-care staff?..... ☐ No ☐ Yes as noted below

E. Any signs/symptoms of head lice?..... ☐ No ☐ Yes as noted 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 follow-up as noted above:

Date/Time: Initials: _____