Health History for Camp

Camp Christian
10299 Maple Dell Rd
Marysville, Oh 43040

Bring Form to Camp!

→ **Photocopy of front and back of health insurance card must be attached to this form.** ☐ ______

Year______ Cabin______ Name______

PLEASE PRINT

Name____
Last First Middle

Home address____
Street address City State Zip

Birth date______ ______ Age at camp______ Gender: ☐ Male ☐ Female

Custodial parent/guardian______________________Phone______________

Home address____
(If different than above) Street address City State Zip

Cellular Phone______________________Business Phone______________

Second parent or guardian or emergency contact______________________

Home address____
(If different than above) Street address City State Zip

Cellular Phone______________________Business Phone______________

In an emergency, *if parents/guardians are not available*, notify:

Name____

Relationship______________________Phone______________

Address____
Street address City State Zip

Insurance Information:

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

If so, indicate carrier or plan name______________________Group #______________

Name of family physician______________________Phone______________

Name of family dentist/orthodontist______________________Phone______________

Name of medical specialist______________________Phone______________

Your family insurance is considered the primary insurer for your child. We carry only supplemental insurance and only for accidents. You will be billed for any emergency care provided by the doctor and/or hospital emergency room. Our insurance will pay for that amount not covered by your insurance or in the case that your child is not insured.

Important - This box MUST BE signed for attendance

____ This health history is correct so far as I know, and the person described here has permission to engage in all camp activities except as noted.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for me or my child. In the event I cannot be reached (or cannot speak) in an emergency, I give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child (or myself) as named above. * (NOTE: Parents will be contacted if the camper has an illness or accident that is of concern to the Camp Nurse and Camp Director. Parents will be contacted/consulted in the event that a trip to Urgent Care, Emergency Room or other off-site medical attention is necessary. In the event that the parents cannot be reached, the Health Caregiver or Camp Director will try to reach an Emergency Contact Person listed above.) I also give permission to the medical personnel to administer over-the-counter medication (as listed on page 3) as deemed appropriate according to the camper's complaints or condition. The dosage or applications will be directed on the labels of each medication and may be the generic equivalent. The completed forms may be photocopied for trips out of camp.

Signature of parent/guardian ______________________________

Printed Name______________________________ Date ______________

Health History

The following must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp healthcare personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide completed information so that the camp can be aware of your needs.

Allergies: List all known. Possible reaction and management of the reaction.

Medication Allergies (List)

____

Food Allergies (List)

____

Other Allergies (List) - Include insect stings, hay fever, asthma, animal dander, etc.

____

Restrictions

The following restrictions apply to this individual:

Dietary

- ☐ Does not eat red meat
- ☐ Does not eat pork
- ☐ Does not eat eggs
- ☐ Does not eat poultry
- ☐ Does not eat seafood
- ☐ Does not eat dairy products
- ☐ Other (Describe)____

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

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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. **<u>Keep medications 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.</u>**

___ This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1________________________Dosage__________Specific times taken each day________________

Reason for taking____

Med #2________________________Dosage__________Specific times taken each day________________

Reason for taking____

Med #3________________________Dosage__________Specific times taken each day________________

Reason for taking____

Attach additional pages for more medications.

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

____

☐ ________

Circle:

Which of the following has the participant had:	**Please give all dates of immunizations for:** **Vaccine**	**Dates:** Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
Chicken Pox	DTP	_____	_____	______	______	______	_____
Measles	TD (tetanus/diphtheria)	_____	_____	______	______	______	_____
German Measles	Tetanus	_____	_____	______	______	______	
Mumps	Polio	_____	_____	______	______	______	
Hepatitis A	MMR	_____	_____				
Hepatitis B	or Measles	_____	_____				
Hepatitis C	or Mumps	_____	_____				
	or Rubella	_____	_____				
TB Mantoux Test	Haemophilus Influenza B	_____	_____	______	______		
Date of Last Test _________	Hepatitis B	_____	_____	______			
Result: Positive Negative	Varicella (Chicken Pox)	_____	_____				

General Questions (Explain "yes" answers below.)

Has/does the participant:

		Yes	No
1.	Had any recent injury, illness, infectious disease?	☐	☐
2.	Ever been hospitalized?	☐	☐
3.	Ever had surgery?	☐	☐
4.	Have frequent headaches?	☐	☐
5.	Ever had a head injury?	☐	☐
6.	Ever been knocked unconscious?	☐	☐
7.	Wear glasses, contacts, or protective eye wear?	☐	☐
8.	Ever had frequent ear infections?	☐	☐
9.	Ever passed out during or after exercise?	☐	☐
10.	Ever been dizzy during or after exercise?	☐	☐
11.	Ever had seizures?	☐	☐
12.	Ever had chest pain during or after exercise?	☐	☐
13.	Ever had high blood pressure?	☐	☐
14.	Ever been diagnosed with a heart murmur?	☐	☐
15.	Ever had back problems?	☐	☐
16.	Ever had problems with joints (e.g., knees, ankles)?	☐	☐
17.	Have an orthodontic appliance being brought to camp?	☐	☐
18.	Have a chronic or recurring illness/ condition?	☐	☐
19.	Have any skin problems (e.g., itching, rash, acne)?	☐	☐
20.	Have diabetes?	☐	☐
21.	Have asthma?	☐	☐
22.	Had mononucleosis in the past 12 months?	☐	☐
23.	Had problems with diarrhea/ constipation?	☐	☐
24.	Have problems with sleepwalking?	☐	☐
25.	If female, have an abnormal menstrual history?	☐	☐
26.	Have a history of bed-wetting?	☐	☐
27.	Ever had an eating disorder?	☐	☐
28.	Ever had emotional difficulties for which professional help was sought?	☐	☐
29.	Ever had problems with homesickness?	☐	☐
30.	Can the camper swim?	☐	☐

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

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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.

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Over the Counter Medications (**if you do not want your child treated with any of the following** while at camp, cross it off and initial)

Camper Complaint	**Medicine Administered** (May be generic equivalent)
Minor aches & pains, headaches, toothaches, or elevated temperature	Motrin or Tylenol
Itching, rash, poison ivy, insect bites or sunburn	Benadryl, Calamine, Aveno, 1% Hydrocortisone Cream, Technu, Aloe
Mild diarrhea (w/o other symptoms)	Immodium
Upset stomach	Tums, Pepto Bismal, Mylanta
Minor cuts, scratches, abrasions	Triple antibiotic (Neosporin), Sterile Wipes
Mosquito, insect bites	Insect repellent, Skeeter Stik, After Bite
Itchy, watery eyes, sneezing, runny	Benadryl tablet
Stuffy Nose	Sudafed
Sore throat	Throat lozenges
Sun exposure	Sunscreen, Aloe