



### CAMPER HEALTH FORM

Please bring this COMPLETED form and any additional waivers to Camp Check-In.

Camp Dates: start \_\_\_\_\_ end \_\_\_\_\_ Location: \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Theme: \_\_\_\_\_

Camper Name: \_\_\_\_\_  
First Middle Last

Birth Date \_\_\_\_\_ Age on arrival at camp: \_\_\_\_\_ Grade in Fall 2022: \_\_\_\_\_  
Month/Day/Year

Camper Home Address: \_\_\_\_\_  
Street Address City State Zip Code

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: \_\_\_\_\_ 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 is lactose intolerant.  This camper is gluten intolerant.  
 Other, *please explain in space.*

**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.)*

**Encouraged:** Are there specific activities to be encouraged?

**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.*

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber \_\_\_\_\_ Insurance Company Phone Number (\_\_\_\_) \_\_\_\_\_

**Parent/Guardian Authorization for Health Care:** *Please initial next to each statement below*

\_\_\_\_ I confirm that 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 my permission for camp staff to provide basic medical care under their scope of training through First Aid and CPR.

\_\_\_\_ 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 Name \_\_\_\_\_  
First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
(For Camp Use) Theme: \_\_\_\_\_  
(For Camp Use) Session Start Date: \_\_\_\_\_

# CAMPER HEALTH FORM

continued...

Camper Name: \_\_\_\_\_  
First Middle Last

Birth Date: \_\_\_\_\_  
Month/Day/Year

**Immunization History:** 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
Diphtheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster * (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative <input type="checkbox"/> Positive
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**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 have original 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
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> 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)                                   | Pseudoephedrine decongestant (Sudafed)                        |
| Phenylephrine decongestant (Sudafed PE)                   | Guaifenesin cough syrup (Robitussin)                          |
| Antihistamine/allergy medicine                            | Generic cough drops   |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Antibiotic cream  |
| Sore throat spray   | Aloe  |
| Calamine lotion   | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |
| Laxatives for constipation (Ex-Lax)                       | Sunscreen (if no, see additional question)                    |
| Ibuprofen (Advil, Motrin)                                 | Bug Spray (if no, see additional question)                    |

**If you said no to Sunscreen, explain your preferred method of UV radiation protection:**

\_\_\_\_\_

**If you said no to Bug Spray, explain your preferred method of insect-borne illness protection:**

\_\_\_\_\_

# CAMPER HEALTH FORM

continued...

Camper Name: \_\_\_\_\_

First

Middle

Last

Birth Date: \_\_\_\_\_  
Month/Day/Year

## General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

- |  |  |   |  |
|--|--|---|--|
| 1. Ever been hospitalized? .....                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?.....    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? .....                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Have problems with periods/menstruation?.....                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? .....               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking/nightmares? .. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? .....                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems?.....                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? .....                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting?.....                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?.....         | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?.....                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? .....                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems?.....                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? .....                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?.....       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches? .....                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Have frequent/prolonged nosebleeds?.....                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? ..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 22. Had recent ear/sinus infections?.....                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Had fainting or dizziness? .....                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 23. Has experienced homesickness?.....                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Passed out/had chest pain during exercise? .....     | <input type="checkbox"/> Yes <input type="checkbox"/> 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 experienced and/or been treated for anxiety? .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. During the past 12 months, seen a professional to address mental/emotional health concerns?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a significant life event that continues to affect the camper's life?.....<br>(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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.**

## Camper Pickup List:

To assure the safety of your camper, we ask that you completely fill out this information. By listing the individuals below, you authorize these people to pick up your camper in an emergency or at the end of camp. Our staff will only release campers to those indicated below, no exceptions will be made. Photo identification will be required by ALL designated "Pick-ups". Campers will not be released without photo identification; this procedure ensures that your camper is released ONLY to those individuals who have been authorized by you.

**\*Please do not forget to list yourself and your spouse/partner.\***

Pickup Person # 1: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Pickup Person # 2: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Pickup Person # 3: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Pickup Person # 4: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Pickup Person # 5: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Pickup Person # 6: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Parents/Guardians: STOP here. The rest of this form is completed when the camper arrives at camp. Keep a copy for your records.**

