

Cohutta Springs Youth Camp Health History Form

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Camper cannot be accepted without this form – this must be presented at Camper Check-In. DO NOT mail, email or fax this form.

This form is to be completed no more than seven (7) days prior to registered camp date.

Office Use:
Cabin # _____

Camper's Legal Name: First: _____ Middle: _____ Last: _____	
Age _____	Birthdate _____ / _____ / _____ Month / Day / Year
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Camper Mailing Address	
City _____	State _____ Zip _____
Who has legal custody of camper? <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____	

Parent/Guardian with legal custody to be contacted in case of illness or injury:	
Name: _____	Relation to Camper: _____
Primary Phone: () _____	Alternate Phone: () _____
2nd parent/guardian or other emergency contact:	
Name: _____	Relation to Camper: _____
Primary Phone: () _____	
Additional emergency contact:	
Name (s): _____	Relation to Camper: _____
Primary Phone: () _____	

Camper Health Insurance Information	
This camper is covered by family medical/hospital insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Insurance Company _____	Phone: () _____
Please Note: Cohutta Springs Youth Camp has limited accident insurance. The camp will provide the primary coverage to a certain level and family insurance will be secondary. Health insurance remains the family's responsibility, i.e. flu, earaches, and other personal health issues. The specific coverage and limitations is available from the Georgia-Cumberland Conference Risk Management Department.	

Immunizations	
Are all your child's immunizations, required for school, up-to-date? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tetanus Status: Month _____ Year _____ (The month and year of the most recent Tetanus shot is required)	
If doctor advises, may Tetanus Immunization be administered? <input type="checkbox"/> Yes <input type="checkbox"/> No	
It is recommended that the child's immunization record is turned in at Camper Check-in	
If your child has not been fully immunized, please sign the following statement:	
<input type="checkbox"/> I understand and accept the risks to my child from not being fully immunized.	
*Legal Parent/Guardian's Signature _____	Date _____

Allergies	
Does this camper have any known allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", this camper is allergic to: <input type="checkbox"/> Food <input type="checkbox"/> Medicine <input type="checkbox"/> Environment (insect, pollen, etc.) <input type="checkbox"/> Other _____	
List all Allergies:	Reaction

Camper Interaction Information

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Camper Name _____

Birthdate _____
Month / Day / Year

First Last

Office Use:
Cabin # _____

Activity Restrictions

I have reviewed all activities of the camp and feel the camper can participate without restrictions. Yes No
 If "No", please describe activity restrictions and reason.

Activity Restrictions:	Reason

Mental, Emotional, and Social Health: Check "Yes" or "No" if the camper has:

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 this space, noting the number of the questions. If more space is needed, attach to form.

Additional information for nurse or counselor concerning physical, medical, psychological, or behavioral needs:

Additional Information:

Note: If your child is exposed to head lice within two weeks before camp start, please make certain your child has been properly treated by a health professional prior to coming. If during Camper Check-in, it is determined that your child is infected with head lice, s/he will not be admitted to camp

Communicable Disease: Has your child been exposed to any contagious/communicable disease during the three weeks prior to camp attendance (Flu, Mono, TB, Virus, etc)?

Yes No If Yes, please specify _____

Travel: For travel outside the US, please name countries visited and dates traveled:

Country:	Dates Traveled:

Medications/Vitamins/Natural Remedies:

Will this camper take any medications while attending camp (prescription or over-the-counter)? Yes No

List medications, vitamins, etc. to be taken: (Any psychotropic drugs must be at the therapeutic level – 3 months minimum use.)

Medication Name*	Dose	Frequency	Reason	What happens if dose is missed?
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Dinner <input type="checkbox"/> Other <input type="checkbox"/> Lunch <input type="checkbox"/> Bedtime _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Dinner <input type="checkbox"/> Other <input type="checkbox"/> Lunch <input type="checkbox"/> Bedtime _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Dinner <input type="checkbox"/> Other <input type="checkbox"/> Lunch <input type="checkbox"/> Bedtime _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Dinner <input type="checkbox"/> Other <input type="checkbox"/> Lunch <input type="checkbox"/> Bedtime _____		

*All medications, vitamins or natural remedies (prescription and/or over-the-counter) **must be brought in the original bottle** and turned into the nurse at Camper Check-in

