Health History Form

(Revised 04/2024)

Participant Name:________________________ Session(s) Attending: __________

Parents/Guardians or Staff: Please follow these directions for completion of this Health Form.

1. Complete pages 1, 2, 3, and 4 of the **Health History Section**.
2. Complete the top of the **Medical Recommendations Section** (pg.5). Take both the **Health History** (pgs.1-4) and the **Medical Recommendations** form (pg.5) to a licensed health care provider for review and completion. This physical must be within **12 months** of attending camp.
3. Complete page 6 **HIPAA Authorization.** This information may be required after an accident/illness occurring at camp and covered by Seacamp policies.
4. All campers participating in SCUBA and all staff participating in Skin Diving and SCUBA training and programs must also complete **Diver Medical Participant Questionnaire/Medical Examiner's Evaluation Form.** This second document must also be taken to a licensed health care provider for review and completion.
5. The **Health History** and **Medical Recommendations** must be signed by both parents/guardians and the camper. The **Diver Medical Participant Questionnaire** must be signed by both parents/guardians and the camper.
6. The **Medical Recommendations** Section & **Diver Medical Examiner's Evaluation Form** must be signed by a Doctor of Medicine (M.D.), a Doctor of Osteopathic Medicine (D.O.), a Nurse Practitioner (ARNP), or a Physician's Assistant (PA-C). No other medical personal will be accepted. These forms may not be signed by a camper's family member and must be signed by a third party.
7. Photocopy the front and back of your health insurance card and attach the copy to this form.
8. Send pages 1-6 of the Seacamp document and page 1-6 of the SCUBA document to Seacamp and keep a complete copy for your records.

Name of Participant: ______________________________________ Date of birth: ______________ Age at camp: __________
Last First Middle

Home Address: ____
Street City State Zip Code

Social Security Number:____ Gender: ☐ Male ☐ Female

Custodial Parent/Guardian:____ Phone #:______________

Home Address: ____
(if different than above) Street City State Zip Code

Second Parent/Guardian:____ Phone #:______________

Address:____
Street City State Zip Code

If parents not available in an emergency, notify:____

Relationship:____ Phone #:______________

Address:____
Street City State Zip Code

Name of primary doctor(s):____ Phone #:______________

Address:____
Street City State Zip Code

Name of dentist(s)/orthodontist(s):____ Phone #:______________

Address:____
Street City State Zip Code

Insurance Information:

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

If so, indicate carrier or plan name____ Group #______________

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

Important: The boxes below must be complete for attendance

This health history is correct and accurately reflects the health status of the person 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 health, routine health care, and emergency situations. I also give permission for the camp to arrange related transportation. 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 or if a staff member, myself. 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. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I authorize Seacamp or other authorized representatives of Seacamp Association, Inc. to obtain information regarding the above named participant's medical history, health record, physical condition, and diagnosis from treating providers. These providers may talk with those people authorized by Seacamp about the participant's health status.

Signature of mother/guardian or adult camper/staff:__________________________________

Printed Name:______________________________ Date:______________

Signature of father/guardian:__________________________________

Printed Name:______________________________ Date:______________

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

Both Parents Must Sign No digital signatures accepted

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

Signature of minor camper:______________________________ Date:______________

Health History Form

Participant Name:____

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care 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 complete information so the camp can be aware of your needs.

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations MUST be current. 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
Diptheria, 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) □ Had Chicken Pox Date:_____						
Meningococcal meningitis (MCV4)						
COVID-19 Vaccinations						

Tuberculosis (TB) Test	Date:	□ Negative	□ Positive

No digital signatures accepted

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 Mother/Guardian: ______________________________ Date: ________________

Signature of Father/Guardian: ______________________________ Date: ________________

Allergies (List all known) — Describe reaction and management of the reaction.

Medication Allergies (list)

______________________ ______________________

______________________ ______________________

______________________ ______________________

Food Allergies (list)

______________________ ______________________

______________________ ______________________

______________________ ______________________

Environmental Allergies (insect stings, hay fever, asthma, animal dander, etc.) (list)

______________________ ______________________

______________________ ______________________

______________________ ______________________

Other Allergies (list)

______________________ ______________________

______________________ ______________________

______________________ ______________________

Health History Form

Participant Name:______________________________

Medication: ☐ This participant will not take any daily medications while attending camp.

☐ This participant 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 note that all prescription medication must be in original containers and clearly labeled with the camper/staff name, the name and strength of the drug, and the correct, current dosage. Non-prescription medications, as well, must be in their original packages.

Any medications NOT labeled as above and not listed on this form will not be dispensed to the camper/staff.

Please bring enough to last the session(s) and no more. If the prescribing physician is not your family physician, please make sure that the medications are listed below.

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:_______		

Do any of the above listed medications increase photosensitivity? (Specify) ______________________________

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 participant should not be given.

The Health Center stocks a selection of over-the-counter medications. Among these are a variety of pain relievers, seasickness preventatives, antacids, decongestants, and cold medications. Dosages are administered by the nurses according to the directions on the bottle unless otherwise directed by the camp physician. It is not necessary to bring these types of medication to camp, and we ask that you leave such medications, as well as Band-Aids, hydrogen peroxide, etc., at home. 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 participant should* not *be given and include any other not listed*.**

Acetaminophen (ex. Tylenol)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine
Bismuth subsalicylate for diarrhea (ex. Pepto-Bismol)
Dextromethorphan cough syrup
Seasickness Prevention

Caladryl
Laxatives for constipation
Ibuprofen (ex. Advil/Ibuprofen)
Pseudoephedrine decongestant (ex. Sudafed)
Guaifenesin cough syrup
Antacids

Lice shampoo or cream
Antibiotic cream/ointment
Generic cough drops
Cortisone Cream
Sore throat spray
Aloe

Other: ______________________________

Diet/Nutrition:

□ This participant eats a regular diet.
□ This participant eats a regular vegetarian diet.
□ This participant has special food needs. **(Please describe.)**

Restrictions:

□ I have reviewed the program and activities of the camp and feel the participant can participate without restrictions.
□ I have reviewed the program and activities of the camp and feel the participant can participate with the following restrictions or adaptations. **(Please describe.)**

Health History Form

Participant Name:____

General Health History: *Check* YES *or* NO *for each statement.*

Has/does the participant:

Question	Yes	No
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/illness?	☐ Yes	☐ No
6) Have asthma/shortness of breath/wheezing?	☐ Yes	☐ No
7) Have diabetes?	☐ Yes	☐ No
8) Had mononucleosis (mono) during the past 12 months?	☐ Yes	☐ No
9) Traveled outside the country in the past 9 months?	☐ Yes	☐ No
10) Do you have any body piercings? (Where)	☐ Yes	☐ No
11) Do you have tattoos or other body art?	☐ Yes	☐ No
12) Wear glasses, contacts, or protective eyewear?	☐ Yes	☐ No
13) Had fainting or dizziness?	☐ Yes	☐ No
14) Passed out/had chest pain during exercise?	☐ Yes	☐ No
15) Had chest pain during or after exercise?	☐ Yes	☐ No
16) If female, have problems with periods/menstruation?	☐ Yes	☐ No
17) Have problems with falling asleep/sleepwalking?	☐ Yes	☐ No
18) Ever had back/joint problems?	☐ Yes	☐ No
19) Have a history of bedwetting?	☐ Yes	☐ No
20) Have problems with diarrhea/constipation?	☐ Yes	☐ No
21) Have any skin problems (e.g. itching, rash, acne)?	☐ Yes	☐ No
22) Ever been knocked unconscious?	☐ Yes	☐ No
23) Ever had a head injury?	☐ Yes	☐ No
24) Ever had high blood pressure?	☐ Yes	☐ No
25) Had a heart murmur?	☐ Yes	☐ No
26) Had frequent ear infections?	☐ Yes	☐ No
27) Ever had seizures?	☐ Yes	☐ No
28) Had frequent headaches?	☐ Yes	☐ No
29) Ever had an eating disorder?	☐ Yes	☐ No
30) Have an orthodontic appliance being brought to camp?	☐ Yes	☐ No
31) Ever snore, sleep talk, or make other noises while sleeping?	☐ Yes	☐ No
32) Require reading or listening to music to fall asleep?	☐ Yes	☐ No

Please explain any* YES *answers, noting the number of the questions. (Attach additional information if needed.) For travel outside the country, please name countries visited and dates of travel.

Mental/Emotional/Social Health: Check *YES* or *NO* for each statement.

Has the participant:

Question	Yes	No
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. (Attach additional information if needed.) The camp may contact you for additional information.

What have we forgotten to ask? Please provide in the space below any additional information about the participant's health that you think important or is there any other information we need for the participant to be successful at camp. *(Attach additional information if needed.)*

Keep a copy of the Health History form for your records.

Medical Recommendations Form

Participant Name:____
First / Middle / Last

Gender: ☐ Male ☐ Female

Date of Birth:_______________ Age on arrival at Camp: ___________

Home Address:____

Parent/Guardian Home Phone:_________________________

Parent/Guardian Cell Phone:__________________________

Note: The remainder of this form is to be completed by a licensed physician.

The following non-prescription medications are stocked in the camp Health Center and are used on an *as needed basis* to manage illness and injury.

Physician: Cross out those items the camper should ***NOT*** be given.

Guaifenesin cough syrup	Aloe
Lice shampoo or cream	Ibuprofen
Laxatives for constipation	Sore throat spray
Antibiotic cream/ointment	Acetaminophen
Antihistamine/allergy medicine	Caladryl
Generic cough drops	Cortisone Cream
Pseudoephedrine decongestant	Antacids
Dextromethorphan cough syrup	Seasickness Prevention

Bismuth subsalicylate for diarrhea

Diphenhydramine antihistamine/allergy medicine

Other:____________________________________

Physician Notes (Please read before completing form):

Please review the HEALTH HISTORY FORM and complete all remaining sections of this form. Attach any additional information as needed.

Physical exam done today: ☐ Yes ☐ No

If NO, date of last physical: _______________

*Seacamp policy requires that campers/staff must have an annual physical. This physical must be within **12 months** of attending camp.

Weight:__________lbs Height:_____ft_____in BP________/_________

Allergies: ☐ No known allergies ☐ Food *(List)*:

☐ Medications *(List)*: ☐ Other allergies *(List)*:

☐ Environment – eg. insect stings, hay fever, animal dander *(List)*:

Describe previous reactions:

Diet/Nutrition: ☐ Eats a regular diet

☐ Has a medically prescribed meal plan or dietary restrictions *(Describe Below)*:

The participant is undergoing treatment at this time for the following conditions: ☐ No treatment ☐ Yes *(Describe Below)*:

Medication (Please list ALL medications, including over-the-counter or nonprescription drugs, taken by this person)**:**

☐ This person takes no medications on a routine basis.

☐ This person will take the following prescribed medication(s) while at camp *(describe below)*:

Medications/Strength	Dosage	Indication	Remarks

Do any of the listed medications increase photosensitivity? *(Specify)*: ______________________________

Other treatments/therapies to be continued at camp: ☐ No ☐ Yes *(Please describe – attach additional information if needed)* :

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes

If yes, what do you recommend? *(Please describe – attach additional information if needed)*

Additional information for health care staff at camp: *(Attach additional information if needed)*

I have reviewed the HEALTH HISTORY FORM (pages 1-4) and have discussed the camp program with the individual and/or the participant's parent(s)/guardian(s). It is my opinion that this individual is physically and emotionally fit to participate in an active camp program (except as noted above).

Physician Signature:______________________ Print Name:____________________ Title:______________

Address:____

Phone #:____________________ Date:____________________

HIPAA AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

NOTE: This information may be required for use after an accident/illness occurring at Seacamp and covered by Seacamp insurance policies.

CAMPER/STAFF NAME:______________________________________

TO: ____(Health Care Provider)

(to be completed in the event of a doctor's visit)

RE:____(Participant/Patient/Minor)

Pursuant to HIPAA standards for Privacy of Individually Identified Health Information, 45 C.F.R. 164.512 and 164.508, I hereby authorize you to use or disclose my protected health information, as described below.

I further authorize the following individuals or organizations to receive such health information:

Reece Spencer, Executive Director
Seacamp Association, Inc.
1300 Big Pine Avenue
Big Pine Key, FL 33043

With a copy to:
Camper/Minor/Participant's Parent

This information to be used or disclosed includes the following specified information to allow Seacamp Association, Inc. to communicate with the above Provider regarding the Participant/Patient/Minor's medical condition, care and treatment while the Participant/Patient/Minor is a camper a Seacamp Association, Inc, such that this information may be utilized by Seacamp Association, Inc. to best accommodate the Participant/Patient/Minor and his/her parents during his/her stay at Seacamp Association, Inc.

The complete medical record, including and all notes and billing statements during the approximate period of time from beginning date of service to current date (including information related to identity, diagnosis, prognosis and/or treatment, which may include substance abuse, mental health, and/or HIV information), including admission applications, academic transcripts and performance assessments.

I understand that the information in my health record may include relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. I authorize the release of such information, with the following exception(s): ____

Federal and state laws protect the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected. However, the recipient may be prohibited from disclosing any substance abuse information under the federal confidentiality requirements from alcohol and drug abuse patient records and Public Health Service Act. Such information may not be used to criminally investigate or prosecute any alcohol and drug patient. Further, pursuant to F.S.381.002(2)(a), state law prohibits a recipient from making any further disclosure to test results relating to HIV or AIDS without the specific written consent of the person to whom such information pertains. A general authorization for the release of medical or other information is NOT sufficient for such purpose.

This authorization will expire upon initial response to the above request, or within 180 days of the date of the execution by the parent below, whichever occurs first. I understand that I need not sign this Authorization in order to ensure health care treatment, payment, enrollment in any health plan, or eligibility for benefits. I understand that if this authorization is sought by covered entity I will be given a copy of this Authorization, after signing it.

__________(Initial if applicable) I acknowledge receipt of my copy of my medical record.

Signature of Patient/Authorized Representative (include relationship or nature of authority):

____ Date________________________________

Natural Guardian/Parent of Participant Minor/Adult Camper/Staff

____ Date________________________________

Natural Guardian/Parent of Participant Minor

PLEASE READ AND COMPLETE THE INFORMATION ON THIS DOCUMENT