

CAMPER HEALTH FORM

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

american **CAMP** association®

CAMP BAYS MOUNTAIN HOLSTON CONFERENCE CAMP AND RETREAT MINISTRIES

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last

Male Female Birth Date _____ Age on arrival at camp: _____
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below.

The Camper Health Form is an on-line form that can be completed in your camper's on-line record in our secure on-line registration system. If you complete it on-line, you are finished. Please do not complete it again.

If you are unable to complete it on-line, please complete the paper form and bring it with you to Check-in at camp at the beginning of your camp session.

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.)

Medical Insurance Information:

This camper is covered by family medical/hospital insurance Yes No

Insurance Company _____ Policy Number _____
Subscriber _____ Insurance Company Phone Number (____) _____

Parent/Guardian Authorization for Health Care:

I hereby give permission to the medical personnel to provide routine health care; to administer prescribed medications; and to administer emergency treatment for me/my child, including, but not limited to X-rays, routine tests and treatment and/or hospitalization; and to provide or arrange necessary related transportation for me/my child. I also agree to the release of any records necessary for treatment, referral, billing or insurance purposes

If the person named herein is a minor, it is my intention that representatives of the camp be considered "personal representatives" for the purpose of disclosing health information that is protected under the Health Insurance Portability and Accountability Act of 1996. I also agree to the disclosure to camp representatives of protected health information of the person named herein in order to provide information related to the person's ability to participate in camp activities; and if the person named herein is a minor, to provide information to the camp representatives to keep me informed of my child's health situation

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the named person. This completed form may be photocopied for trips out of camp.

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 HEALTH HISTORY FORM 1

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Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must include date to meet ACA Standard.

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. All medications are required to be in the 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
			<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) | 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) |

CAMPER HEALTH HISTORY FORM 1

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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 | 11. Had fainting or dizziness? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? | <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 |
| 4. Had a recent infectious disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? | <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 |

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)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect the camper's life?.....
(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.**

Parents/Guardians: Thank you for fully completing this form for the safety of your camper while at camp. Keep a copy for your records.