Cohutta Springs Youth Camp Health History Form

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: ☐ Female ☐ Male
Camper Mailing Address		
City	State	Zip
Who has legal custody of camper? ☐ Both Parents ☐ Mother ☐ Father ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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:

☐ *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? ☐ Yes ☐ No

If "Yes", this camper is allergic to: ☐ Food ☐ Medicine ☐ Environment (insect, pollen, etc.) ☐ Other

List all Allergies:	Reaction

Camper Interaction Information

Camper Name_____
First Last

Birthdate _____/_____/_____
Month / Day / Year

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?
		☐ Breakfast ☐ Dinner ☐ Other ☐ Lunch ☐ Bedtime _____		
		☐ Breakfast ☐ Dinner ☐ Other ☐ Lunch ☐ Bedtime _____		
		☐ Breakfast ☐ Dinner ☐ Other ☐ Lunch ☐ Bedtime _____		
		☐ Breakfast ☐ Dinner ☐ Other ☐ Lunch ☐ 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**

Camper Medical Information

Camper Name_____
First Last

Birthdate _____/_____/_____
Month/Day/Year

Office Use:
Cabin #_____

Medications at Camp:

The following over-the-counter medications may be stocked in the Camp Clinic and may be used on an as needed basis to manage illness and/or injury. The camp medication supply includes, but is not limited to the following list. These medications will be administered under the direction of the camp nurse. Dosages will be as listed on labels. Generic equivalents may be used if available. Please check YES if you approve or NO if you do not approve of the medication to use:

Yes	No		Yes	No	
☐	☐	Acetaminophen (Tylenol)	☐	☐	Diphenhydramine antihistamine/allergy medicine (Benadryl)
☐	☐	Ibuprofen (Advil, Motrin)	☐	☐	Antihistamine/allergy medicine
☐	☐	Throat lozenges for sore throats	☐	☐	Pseudoephedrine decongestant (Sudafed)
☐	☐	Sore throat spray (Chloraseptic)	☐	☐	Phenylephrine decongestant (Sudafed PE)
☐	☐	Calamine lotion	☐	☐	Guaifenesin cough syrup (Robitussin)
☐	☐	Antibiotic cream	☐	☐	Dextromethorphan cough syrup (Robitussin DM)
☐	☐	Aloe	☐	☐	Bismuth subsalicylate for diarrhea (Immodium, Pepto-Bismol)
☐	☐	Ointment for rash (Hydrocortisone)	☐	☐	Upset stomach/nausea/indigestion (Tums, Pepto-Bismol)
☐	☐	Sunscreen	☐	☐	Other _____
☐	☐	Laxative for constipation (Ex-lax)			

General Health History: Check "Yes" or "No" if the camper **HAS or HAD** a history of the following:

1. Asthma/wheezing	☐ Yes	☐ No	14. Head Lice	☐ Yes	☐ No
2. Athlete's Foot	☐ Yes	☐ No	15. Heart Condition	☐ Yes	☐ No
3. Back or joint problems	☐ Yes	☐ No	16. Mononucleosis in past 12 months	☐ Yes	☐ No
4. Bedwetting	☐ Yes	☐ No	17. Passed out or chest pain during exercise	☐ Yes	☐ No
5. Concussion	☐ Yes	☐ No	18. Period/Menstruation Problems	☐ Yes	☐ No
6. Diabetes	☐ Yes	☐ No	19. Recurrent/chronic illnesses	☐ Yes	☐ No
7. Diarrhea/constipation	☐ Yes	☐ No	20. Seizure Disorder	☐ Yes	☐ No
8. Ear Infections/Ear Tubes (circle)	☐ Yes	☐ No	21. Sinusitis	☐ Yes	☐ No
9. Eye Glasses/Contacts (circle)	☐ Yes	☐ No	22. Skin problems	☐ Yes	☐ No
10. Fainting or dizziness	☐ Yes	☐ No	23. Sleep problems or Sleepwalking	☐ Yes	☐ No
11. Frequent Sore Throats	☐ Yes	☐ No	24. Sprain, Strain, Dislocation or other Injury	☐ Yes	☐ No
12. Headaches	☐ Yes	☐ No	25. Stomach Upsets	☐ Yes	☐ No
13. Head Injury	☐ Yes	☐ No	26. Other_____		

Note: If during Camper Check-in, your child is found infected with head lice, s/he will not be admitted to camp.

Please explain "Yes" answers in this space, noting the number of the questions. If more space is needed attach to form.

List any hospitalizations, Surgeries or Broken Bones:

Date	Hospitalization/Surgery/Broken Bones	Explanation

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person herein described has permission to participate in all camp activities, except as indicated. The camper will turn in all medications to the Camp Nurse at Camper Check-In and will take any and all prescribed medications sent to camp by the parent/guardian. I give permission to the camp nurse to give over-the-counter medications as indicated above including but not limited to pain medication, cold and flu medication, unless otherwise noted. I give permission to the physician selected by the camp to examine, order any x-ray, 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 permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthetic, medical or surgical treatment to said minor. I understand the information on this form will be shared on a "need to know" basis with camp staff. In addition, the camp has permission to obtain a copy of my child's medical record from providers who treat my child and these providers may talk to attending camp staff about the child's health status. I hereby authorize any hospital or physician, or any other person who has attended or examined said minor to furnish the camp and camp's insurance company or its representative any and all information with respect to any illness, injury, medical history, consultation, prescriptions, or treatment and copies of all hospital or medical records. I accept the conditions stated, including the release of the Georgia Cumberland Conference and Cohutta Springs Youth Camp management from liability in case of serious injury or death.

I hereby give my consent for said camper to ride the Cohutta Springs bus/van for any camp-related activities. I also release all photos and videos taken for Cohutta Springs Youth Camp promotions. This consent shall remain in continuous effect until revoked in writing or until said minor is removed by the parent/legal guardian from the care of Cohutta Springs Youth Camp. I give permission to photocopy this form. A photo copy of this form shall be as effective and valid as the original.

***Parent/Guardian's Signature** **Date** **Relation to Camper**

*This form is to be completed and signed by the parent/guardian whose name appears on the front page.