CAMPER HEALTH HISTORY FORM 1

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

Mail this form to the address below by _______ (date)

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. Attach additional information if needed.

1) ***Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.***
2) ***Send the original, signed FORM 1 to camp by the requested date.***
3) ***Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.***
4) ***After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.***

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(s): __________________________ 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 has special food needs. ***(Please describe below.)***

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

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company______________________________ Policy Number___________________________

Subscriber_____________________________________ InsuranceCompany Phone Number (______)___________________

Parent/Guardian Authorization for Health Care:

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 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) Cabin or Group________________ (For Camp Use) Session Code(s): ________________

CAMPER HEALTH HISTORY FORM 1

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

Camper Name: ____
First Middle Last

Birth Date: ___________
Month/Day/Year

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)						

Tuberculosis (TB) test	Date:	Negative Positive

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 review camp instructions about required packaging/containers. Many states require 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
			Breakfast Lunch Dinner Bedtime Other time:_____________		
			Breakfast Lunch Dinner Bedtime Other time:_____________		
			Breakfast Lunch Dinner Bedtime 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)

Copyright 2008 by American Camping Association, Inc.

Rev. 1/2007 LEE/EAW

CAMPER HEALTH HISTORY FORM 1

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

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? …………………………. 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? .... …………. Yes No
6. Had asthma/wheezing/shortness of breath?...... Yes No
7. Have diabetes? .... …………. Yes No
8. Had seizures? .... Yes No
9. Had headaches? …………………………………. Yes No
10. Wear glasses, contacts, or protective eyewear? Yes No
11. Had fainting or dizziness? .... Yes No
12. Passed out/had chest pain during exercise? ………………. Yes No
13. Had mononucleosis ("mono") during the past 12 months?... Yes No
14. If female, have problems with periods/menstruation?…….. Yes No
15. Have problems with falling asleep/sleepwalking? .... Yes No
16. Ever had back/joint problems?……………...………………...... Yes No
17. Have a history of bedwetting?……………………….……………... Yes No
18. Have problems with diarrhea/constipation?…………………... Yes No
19. Have any skin problems?…………………….......................... Yes No
20. Traveled outside the country in the past 9 months?............. Yes 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)? …………………………........ 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. 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: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

Copyright 2008 by American Camping Association, Inc.

Rev. 1/2007 LEE/EAW

CAMPER HEALTH HISTORY FORM 1

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

Camper Name: ____
First Middle Last

Birth Date: ___________
Month/Day/Year

Individual Health Record (For Camp Use Only)

Initial Screening **Date/Time:** _________ **Initials:** ____________

Screening has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival?........................ No Yes as noted below

B. History of exposure to communicable disease?................................. No Yes as noted below

C. Additions or corrections to information on this health history?........... No Yes as noted below

D. Medication given to health-care staff?.. No Yes as noted below

E. Any signs/symptoms of head lice?... No Yes as noted below

Provider notes: (date/time/initial all entries) ____

Exit Note: Check one of the following:

Left camp this day with no reported illness or injury symptoms.

Left camp this day with the following problem/concern:

____ This

person was told about the problem and instructed about follow-up as noted above: ______________________

Date/Time: ______________ Initials: __________

Copyright 2008 by American Camping Association, Inc.