



Camper Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade on Arrival at Camp: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Parent / Guardian #1**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Parent / Guardian #2**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other: \_\_\_\_\_

**Emergency Contact in event Parents / Guardians can not be reached:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other: \_\_\_\_\_

**Health Care Providers**

Primary Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information**

Camper is covered by family medical/hospital insurance  Yes  No

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group/ID Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

**Diet / Nutrition**

Eats a regular diet  Eats a regular vegetarian diet

Has special food needs (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

\_\_\_\_\_  
 \_\_\_\_\_

**General Health History** Check "Yes" or "No" for each statement. **Please explain "Yes" answers in the space below**

- 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. Passed out/had chest pain during exercise?.....  Yes  No
- 8. Had seizures?.....  Yes  No
- 9. Had fainting or dizziness?.....  Yes  No
- 10. Had headaches?.....  Yes  No
- 11. Had a head injury?.....  Yes  No
- 12. Been knocked unconscious?.....  Yes  No
- 13. Had frequent ear infections?.....  Yes  No

- 14. Had high blood pressure?.....  Yes  No
- 15. Have problems with diarrhea / constipation?.....  Yes  No
- 16. Have a history of bedwetting?.....  Yes  No
- 17. Have problems with falling asleep/sleepwalking?.....  Yes  No
- 18. Wear glasses, contacts, or protective eyewear?.....  Yes  No
- 19. Ever had back / joint problems?.....  Yes  No
- 20. Have any skin problems?.....  Yes  No
- 21. Have diabetes?.....  Yes  No
- 22. Had "mono" in the past 12 months?.....  Yes  No
- 23. Traveled outside the country in the past 9 months?.....  Yes  No
- 24. Have problems with periods / menstruation?.....  Yes  No
- 25. Have an orthodontic appliance being brought to camp?.....  Yes  No

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Previous Conditions** Which of the following has the camper had?  Measles  German Measles  Hepatitis A  Hepatitis C  
 Chicken Pox  Mumps  Hepatitis B

**Mental, Emotional, and Social Health** Check "Yes" or "No" for each statement. **Please explain "Yes" answers in the space below**

- 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?.....  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? (abuse, death of a loved one, divorce, adoption, foster care, new sibling, survived a disaster).....  Yes  No

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



Camper Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Standing Medication Orders** 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. My daughter has permission to take or use the following:

- Tylenol / Acetaminopen   
  Tums / Antacid   
  Pepto Bismol   
  Sudafed / Decongestant   
  Other medications as deemed necessary  
 Benadryl / Antihistamine   
  Advil / Ibuprofen   
  Robitussin / Expectorant   
  Swimmers' Ear / Alcohol Vinegar Solution

**Immunization History** Provide the month and year for each immunization.

	Dose 1 (Month/Year)	Dose 2 (Month/Year)	Dose 3 (Month/Year)	Dose 4 (Month/Year)	Dose 5 (Month/Year)
Diphtheria, tetanus, pertussis (DTaP 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)	_____	_____	_____	_____	_____

**TB Test** Date: \_\_\_\_\_  
 Negative     Positive

**Tetanus**  
 (dT or TdaP) Date: \_\_\_\_\_

**Influenza**  
 Seasonal Date: \_\_\_\_\_  
 H1N1 Date: \_\_\_\_\_

If camper is **NOT** fully immunized, please sign the following statement: I understand and accept the risks to my child from **NOT** being fully immunized.

Printed Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**Parent / Guardian Authorization:**

This health history, including prior pages, is correct and accurately reflects the health status of the camper to whom it pertains. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission the camp to arrange necessary related transportation for me/my child. I understand that providing a safe and positive experience to all campers is of utmost importance to the council and that they reserve the right to make decisions of participation based on the extent of the girl's special needs and our ability to meet those needs in the camp setting and other factors as deemed appropriate. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person named above. This completed form may be photocopied for trips out of camp.

Printed Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**LICENSED MEDICAL PERSONNEL**

Please review this form and complete all remaining sections below

Physical exam must be within last 24 months

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Physical exam done today?

Yes  No If "No", date of last physical \_\_\_\_\_

**Diet / Nutrition** List dietary restrictions  Eats a regular diet

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medications** Include name, dose, frequency  No medications

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Restrictions** List activity restrictions  No restrictions

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies** List all allergies and reactions  No known allergies

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Past Medical / Surgical History**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Physician Authorization:** I have reviewed the camper health history form and have discussed the camp program with the camper's parent(s) / guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Name of Licensed Provider \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_