

2012 CAMPER HEALTH HISTORY FORM

***PARENT/GUARDIAN MUST SIGN AND DATE UPON SUBMISSION – UPDATED HEALTH HISTORY FORM IS REQUIRED FOR ATTENDANCE EACH**

YEAR. The information on this form is gathered to help us provide safe and appropriate health care. All information provided is confidential and will be reviewed by the camp nurse, trip staff and/or camp administration. **This form must be completed and signed by a parent or adult guardian.**

***Campers must have a physical within 24 months of their summer camp session.**

***Attach additional information if needed.**

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 PERSONS 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 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 ALTERNATIVES NECESSARY TO ATTEND CAMP.

CAMPER NAME		GENDER:	SESSION(S) ATTENDING:	
CAMPER HOME ADDRESS			AGE ON ARRIVAL AT CAMP:	DATE OF BIRTH: MM / DD / YEAR
PARENT 1 NAME	PARENT 1 CELL #	PARENT 1 WORK #		
PARENT 2 NAME	PARENT 2 CELL #	PARENT 2 WORK #		
EMERGENCY CONTACT	RELATIONSHIP TO CAMPER	EMERGENCY CONTACT CELL #	EMERGENCY CONTACT WORK #	

THE CAMPER IS COVERED BY FAMILY MEDICAL/HOSPITAL INSURANCE

Yes No

INCLUDE A COPY OF YOUR INSURANCE CARD
COPY BOTH SIDES OF THE CARD SO INFORMATION IS READABLE

INSURANCE CARRIER	POLICY NUMBER	SUBSCRIBER	INSURANCE COMPANY PHONE NUMBER
-------------------	---------------	------------	--------------------------------

GENERAL HEALTH HISTORY HAS/DOES THE CAMPER:

EVER BEEN HOSPITALIZED?	<input type="radio"/> YES	<input type="radio"/> NO	PASSED OUT/HAD CHEST PAIN DURING EXERCISE?	<input type="radio"/> YES	<input type="radio"/> NO
EVER HAD SURGERY?	<input type="radio"/> YES	<input type="radio"/> NO	HAD MONONUCLEOSIS (MONO) DURING THE PAST 12 MONTHS?	<input type="radio"/> YES	<input type="radio"/> NO
HAD RECURRENT/CHRONIC ILLNESSES?	<input type="radio"/> YES	<input type="radio"/> NO	IF FEMALE, HAVE PROBLEMS WITH PERIODS/MENSTRUATION?	<input type="radio"/> YES	<input type="radio"/> NO
HAD A RECENT INFECTIOUS DISEASE?	<input type="radio"/> YES	<input type="radio"/> NO	HAVE PROBLEMS WITH FALLING ASLEEP/SLEEPWALKING?	<input type="radio"/> YES	<input type="radio"/> NO
HAD A RECENT INJURY?	<input type="radio"/> YES	<input type="radio"/> NO	EVER HAD BACK/JOINT PROBLEMS?	<input type="radio"/> YES	<input type="radio"/> NO
HAD ASTHMA/WHEEZING/SHORTNESS OF BREATH?	<input type="radio"/> YES	<input type="radio"/> NO	HAVE A HISTORY OF BEDWETTING?	<input type="radio"/> YES	<input type="radio"/> NO
HAVE DIABETES?	<input type="radio"/> YES	<input type="radio"/> NO	HAVE PROBLEMS WITH DIARRHEA/CONSTIPATION?	<input type="radio"/> YES	<input type="radio"/> NO
HAD SEIZURES?	<input type="radio"/> YES	<input type="radio"/> NO	HAVE ANY SKIN PROBLEMS?	<input type="radio"/> YES	<input type="radio"/> NO
HAD HEADACHES?	<input type="radio"/> YES	<input type="radio"/> NO	TRAVELED OUTSIDE THE COUNTRY IN THE PAST 9 MONTHS?	<input type="radio"/> YES	<input type="radio"/> NO
WEAR GLASSES, CONTACTS, OR PROTECTIVE EYEWEAR?	<input type="radio"/> YES	<input type="radio"/> NO			

PLEASE EXPLAIN ANY "YES" RESPONSES IN THE SPACE PROVIDED:

MEDICATION

This camper will not take any daily medications while attending camp.

This camper will take 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. All medications must have a *med form* completed upon check in to administer.

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

Cross out any of the following items the camper should NOT be given:

Acetaminophen (Tylenol), Ibuprofen (Advil, Motrin), Phenylephrine (Sudafed PE), Pseudoephedrine (Sudafed), Chlorpheniramine Maleate, Guaifenesin (Mucinex), Dextromethorphan (Robitussin DM), Diphenhydramine (Benadryl), Generic Cough Drops, Chloraseptic (Sore Throat Spray), Bismuth Subsalicylate (Pepto-Bismol), Topical Antibiotic Cream, Lice Shampoo or Scabies Cream (Nix or Elimite), Calamine Lotion, Hydrocortisone 1% Cream, Laxatives for Constipation (Ex-Lax), Aloe

ALLERGIES HAS/DOES THE CAMPER:

MEDICATION ALLERGY?	<input type="radio"/> YES	<input type="radio"/> NO	EXPLAIN
FOOD ALLERGY?	<input type="radio"/> YES	<input type="radio"/> NO	EXPLAIN
AIRBORNE ALLERGY?	<input type="radio"/> YES	<input type="radio"/> NO	EXPLAIN
SEVERE ALLERGY?	<input type="radio"/> YES	<input type="radio"/> NO	EXPLAIN
SPECIAL DIETARY NEEDS?	<input type="radio"/> YES	<input type="radio"/> NO	EXPLAIN
			VEGETARIAN? <input type="radio"/> YES <input type="radio"/> NO

ADDITIONAL COMMENTS

Session (s)

Middle Name

First Name

Last Name

SUNSCREEN/INSECT REPELLANT AUTHORIZATION

IF PROVIDED BY THE PARENT, SUNSCREEN OR INSECT REPELLANT SHALL BE LABELED WITH THE CHILD'S NAME, PER DCF251.07(6)(f)2.

<input type="radio"/> YES <input type="radio"/> NO	I AUTHORIZE CAMP TO APPLY SUNSCREEN TO MY CHILD	BRAND NAME	INGREDIENT STRENGTH
<input type="radio"/> YES <input type="radio"/> NO	I AUTHORIZE CAMP TO ALLOW MY CHILD TO SELF-APPLY SUNSCREEN		
<input type="radio"/> YES <input type="radio"/> NO	I AUTHORIZE CAMP TO APPLY REPELLENT TO MY CHILD	BRAND NAME	INGREDIENT STRENGTH
<input type="radio"/> YES <input type="radio"/> NO	I AUTHORIZE CAMP TO ALLOW MY CHILD TO SELF-APPLY REPELLENT		

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.					
IMMUNIZATION		DOSE 1 MONTH/YEAR	DOSE 2 MONTH/YEAR	DOSE 3 MONTH/YEAR	DOSE 4 MONTH/YEAR	DOSE 5 MONTH/YEAR	MOST RECENT MONTH/YEAR
DIPHTHERIA, TETANUS, PERTUSIS(DTaP)OR(TdAP)							
TENTANUS BOOSTER(DT) OF (TdAP)							
MUMPS, MEASLES, RUBELLA(MMR)							
POLIO(IPV)							
HAEMOPHILUS INFLUENZAE TYPE B (HIB)							
PNEUMOCOCCAL (PCV)							
HEPATITIS B							
HEPATITIS A							
VARICELLA (CHICKEN POX)	<input type="radio"/> HAD CHICKEN POX DATE:						
MENINGOCOCCAL MENINGITIS (MCV4)							

TUBERCULOSIS (TB) TEST (IF TESTED)	DATE:	<input type="radio"/> NEGATIVE	<input type="radio"/> 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

MENTAL, EMOTIONAL, AND SOCIAL HEALTH HAS/DOES THE CAMPER:		
HAVE BEEN TREATED FOR ATTENTION DEFICIT DISORDER (ADD) OR ATTENTION DEFICIT/HYPERACTIVITY DISORDER (AD/HD)?	<input type="radio"/> YES	<input type="radio"/> NO
EVER BEEN TREATED FOR EMOTIONAL OR BEHAVIORAL DIFFICULTIES OR AN EATING DISORDER?	<input type="radio"/> YES	<input type="radio"/> NO
DURING THE PAST 12 MONTHS, SEEN A PROFESSIONAL TO ADDRESS MENTAL/EMOTIONAL HEALTH CONCERNS?	<input type="radio"/> YES	<input type="radio"/> NO
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, ETC.)	<input type="radio"/> YES	<input type="radio"/> NO
PLEASE EXPLAIN ANY "YES" RESPONSES IN THE SPACE PROVIDED:		

RESTRICTIONS	
<input type="radio"/>	I HAVE REVIEWED THE PROGRAM AND ACTIVITIES OF THE PHANTOM LAKE YMCA CAMP AND FEEL MY CAMPER CAN PARTICIPATE WITHOUT RESTRICTIONS.
<input type="radio"/>	I HAVE REVIEWED THE PROGRAM AND ACTIVITIES OF PHANTOM LAKE YMCA CAMP AND FEEL THE CAMPER CAN PARTICIPATE WITH THE FOLLOWING RESTRICTIONS OR ADAPTATIONS. (PLEASE DESCRIBE)

ANY ADDITIONAL COMMENTS?
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. <i>ATTACH ADDITIONAL INFORMATION IF NEEDED.</i>
PLEASE EXPLAIN ANY "YES" RESPONSES IN THE SPACE PROVIDED: