



HEALTH RECORD

To insure good health during your child's week of camp, please complete this health record and bring it with you when you register the first day of camp

CAMPER CONTACT INFORMATION

Camper's Name: _____ Birth date: _____ Home phone: _____
 Parent/Guardian 1: _____ Cell Phone _____ Work _____
 Parent/Guardian 2: _____ Cell Phone _____ Work _____
 In case of an emergency, call (if above cannot be reached) _____ Phone: _____
 Physician's Name _____ Physician's Phone _____

INSURANCE INFORMATION

Insurance Information is **REQUIRED** (if you have insurance) since each camper is covered only by limited accident and medical insurance. **You may attach a copy of the front AND back of the insurance card.**

Medical Insurance Carrier _____ Phone (_____) _____ - _____
 Policy # _____ Group _____

Health History:

Date of Last Health Exam: ____/____/____

Please check all that the camper *has or had in the last year*:

- | | |
|--|---|
| <input type="checkbox"/> Convulsions/Epilepsy* | <input type="checkbox"/> Diabetes* |
| <input type="checkbox"/> Immune Dysfunction* | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Heart Defects/Disease* | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Significant Psychiatric Disorder* | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Bleeding/Clotting Disorder* | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Moderate/severe Asthma* | <input type="checkbox"/> Mild Asthma |

Other: _____

Please explain briefly **all** conditions checked below on Page 2 and how it **may or may not** affect involvement in camp activities:

***These conditions require a MD/PA/ARNP signature that the camper is stable and able to participate fully at camp**

Provider Signature _____

Date _____ Provider phone # _____

Allergies: (Indicate severity of all that apply)

- Mild:** No medication required (ex: rash resolves on its own)
Moderate: Medication may be required (ex: Benadryl for hives)
Severe: Life threatening (ex: EpiPen for anaphylaxis)

Specify	Mild	Moderate	Severe
Food			
Animals			
Hay Fever			
Insect Sting			
Medication			
Seasonal			
Other			

Please explain Allergy reaction and details:

****If your camper has food allergies, notify camp at least 1 week prior to the start of your camper's session.****

Immunization History: DO NOT write "Current" or "Up To Date". We need actual dates (month/year). You MAY attach a copy of your child's immunization record directly to this form. IF YOU DON'T HAVE THIS INFORMATION, FILL IN WHATEVER YOU CAN.

Last tetanus booster: ____/____/____

Others if apply to your circumstances:

Hep A _____

Meningococcal: _____

Last Tuberculosis test: _____

(ppd or tine) result: _____

Other: _____

Vaccine	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.
Diphtheria and Tetanus toxoids and pertussis (Dtap or DTP)				
Hepatitis B				
Inactivated Polio				
Measles – mumps- rubella				
Varivax				

Camper Medication:

_____ My child has **no** regular medication to take at camp.

_____ My child **has** medicine (Prescription or OTC) to be administered while at camp (List Below)

Camper Medications: record medication to be given while at camp in the space provided:

Medication	Dosage	AM	Noon	PM	Evening	Bed	As Needed	Other	Reason for taking

Has the Camper ever been prescribed an EPI PEN? YES NO *If yes, the EPI PEN **must** accompany the camper to camp!*

Please send medication in **ORIGINAL CONTAINER**. Otherwise we **cannot** accept it

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.**

- | | | | |
|---|-------------------------|---------------------|----------------|
| Ibuprofen (Advil, Motrin) or Naproxen (Aleve) | Acetaminophen (Tylenol) | Generic Cough Drops | Aloe Gel |
| Diphenhydramine (Benadryl) or nondrowsy antihistamine | Calamine lotion | Tums | Burn cream |
| Dextromethorphan cough syrup (Robitussin DM) | Lice shampoo or cream | Antibiotic cream | Deet repellent |

Please list any additional limitations, conditions, or instructions, about your son/daughter, you wish his/her counselor to be aware of:

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 staff about my child's health status.

I give permission for the camp health personnel to administer the medication as listed on this form, to perform treatment for minor injuries and illnesses, and to perform first aid in the case of more serious injury.

Custodial Parent/Guardian Name (Printed) _____ Relationship to camper _____

Signature of custodial Parent/Guardian _____ Date _____

Confidential: *We respect your privacy. This form is intended to provide necessary medical information. It is reviewed by the nursing staff and your child's counselor(s). In the event of an emergency it may also be reviewed by medical personnel, camp administration and transportation personnel.*