

For
Office
Use

Health History Form for Child Attending Day Camp

Based on reporting standards of the American Camp Association
and the American Academy of Pediatrics

Please return this form to the address below:

Camp W
PO Box 725
Plainview, NY 11803

Year: 2015

Weeks: _____

Grade Group: _____

Name: _____

The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to the Camp Nurse upon participant's arrival in camp. Please provide complete information so that the camp can be fully aware of your child's needs.

Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address _____
Street Address City State Zip

Social security number of camper _____ Gender Male Female

Custodial parent / guardian _____ Phone _____

Home address _____
(if different from above) Street Address City State Zip

Business address _____
Street Address City State Zip

Second parent or guardian or emergency contact _____ Phone _____

Home address _____
(if different from above) Street Address City State Zip

Business address _____
Street Address City State Zip

If not available in an emergency, notify _____ Relationship _____ Phone _____

Home address _____
Street Address City State Zip

Insurance Information

Is the participant covered by family medical / hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____

Photocopy of front and back of health insurance card must be attached to this form.

IMPORTANT – This box must be complete for attendance*

Parent / Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

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 treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. 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.

I also understand and agree that my child will abide by any restrictions placed on his/her participation in camp activities.

Signature of parent or guardian _____

Printed name _____ Date _____

* If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

ALLERGIES: List all known medication, food, and other allergies. Describe reaction and management of the reaction.

Medication allergies: _____

Food allergies: _____

Other allergies: _____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

s campertakes **NO medications** on a routine basis OR This capertakes **medication** as follows:

Med # 1 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____

Med # 1 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____

Attach additional pages for more medications.
 Identify any medications taken during the school year that camper does/may not take during summer: _____

RESTRICTIONS (The following restrictions apply to this individual)

Does not eat: Nuts Dairy products Eggs Other (describe) _____

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary) _____

GENERAL QUESTIONS (Explain "yes" answers below.)

Has / does the participant:		Yes	No			Yes	No
1.	Had any recent injury, illness or infectious disease?			16.	Ever had back problems?		
2.	Have a chronic or recurring illness/condition?			17.	Ever had problems with joints (e.g., knees, ankles)?		
3.	Ever been hospitalized?			18.	Havean orthodonticappliance to be brought to camp?		
4.	Ever had surgery?			19.	Have any skin problems (i.e., itching, rash, acne)?		
5.	Have frequent headaches?			20.	Have diabetes?		
6.	Ever had a head injury?			21.	Have asthma?		
7.	Ever been knocked unconscious?			22.	Had mononucleosis in the past 12 months?		
8.	Wear glasses, contacts, or protective eyewear?			23.	Had problems with diarrhea/constipation?		
9.	Ever had frequent ear infections?			24.	Have problems with sleepwalking?		
10.	Ever passed out during exercise?			25.	If female, have an abnormal menstrual history?		
11.	Ever been dizzy during or after exercise?			26.	Have a history of bed-wetting?		
12.	Ever had seizures?			27.	Ever had an eating disorder?		
13.	Ever had chest pain during or after exercise?			28.	Ever had emotional difficulties for which professional help was sought?		
14.	Ever had high blood pressure?						
15.	Ever been diagnosed with a heart murmur?						

Please explain any "yes" answers, noting the number of the questions. _____

Which of the following has the camper had?
<input type="checkbox"/> Measles
<input type="checkbox"/> Chicken pox
<input type="checkbox"/> German measles
<input type="checkbox"/> Mumps
<input type="checkbox"/> Hepatitis A
<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Hepatitis C

Please provide month & year of immunization or attach immunization report from health care provider.							
(Those noted with Immunization * must be current)	Dose 1 Mo/Yr	Dose 2 Mo/Yr	Dose 3 Mo/Yr	Dose 4 Mo/Yr	Dose 5 Mo/Yr	Mostrecentdose Month/Year	
*Diphtheria/tetanus/pertussis(DTaP) or (TdaP)							
*Tetanus booster (dT) or (TdaP)							
*MMR (mumps/measles/rubella)							
*Polio (IPV)							
Haemophilus influenza type B (HIB)							
Pneumococcal							
Hepatitis B							
Hepatitis A							
Varicella (chicken pox)							
Meningococcal meningitis (MCV4)							

Tuberculosis (TB) test: _____ Date: _____ Negative Positive

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware: _____

Name of family physician _____ Phone _____

Address _____

Name of family dentist / orthodontist _____ Phone _____

Address _____

Camp Use Only: Meds received _____ Updates to health history noted Yes No

Notes: _____