Christian Camps and Conferences

Legal Name: _____ _____
First Middle Last "Nickname"

☐ Male ☐ Female Birth Date _____ Age on arrival at camp: _____
Month/Day/Year

Health History Form

Directions:
1. Parents: Please fill out pages 1 and 2 of this form as much as possible.
2. Provide the form to your child's health care provider for review and completion of pages 3 and 4.
3. **After** the health care provider has completed and signed the form, **return it to the camp by May 1st.**

We suggest you keep a copy of the completed form for your records.

Office Use Only
J-1 J-2 A-1 A-2
M-1 M-2 1 2 3

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 Phone: (_____) _____

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 Phone: (_____) _____

Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): _____ Relationship to Camper: _____ Preferred Phone: (_____) _____

Medical Insurance Information:

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

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.

Name: _____
First Middle Last

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 during the past 12 months? ☐ Yes ☐ No
14. If female, have problems with 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 question. 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.

Does your camper take script or OTC medications? If so a MD/NP/PA must write an order on page 4 of this form or provide other written authorization.

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: _____

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 the form is to be completed by the camper's licensed health-care provider.

Name: _____
First Middle Last

Medical Personnel: Please review the the first two pages of this form and complete all remaining sections of this form. (Pages 3 and 4) Attach additional information if needed.

Weight: _____ lbs Height: _____ft_____in Blood Pressure_____/_____

Physical exam done today: ☐ Yes ☐ No (If "No," date of last physical: _____)

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes

If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

"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 on this form.)

Name of licensed provider (please print): _____Signature: _____Title: _____

Office Address_____
Street City State Zip Code

Telephone: (_____)_____ Date:_____

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 those items the camper should not be given.

Acetaminophen (Tylenol) **Aloe** **Ammonia inhalent** (for fainting) **Bacitracin ointment**
Bactroban 2% ointment (Mupirocin – for skin infection)
Benzocaine gel (Orasol, Anbesol – for toothaches)
Calamine lotion **Calcium Carbonate** (Tums – antacid) **Cetirizine** (Zyrtec – antihistamine)
Dextromethorphan (Robutussin DM, Delsym – cough syrup)
Diphenhydramine (Benadryl – antihistamine) **Epinepherine** (Epipen – for anaphylaxis)
Generic cough drops **Guaifenesin** (Robutussin – cough syrup) **Hydrocortisone 1% cream**
Ibuprofen (Advil, Motrin) **Lidocaine Gel** (pain relieving burn gel)
Loperamide (Immodium AD – antidiarrheal)
Loratadine (Claritin – antihistamine) **Milk of Magnesia** (laxative)
Phenol spray (Chloraseptic – Sore throat spray)
Phenylephrine (Sudafed PE – decongestant) **Pseudophedrine** (Sudafed – decongestant)
Tolnaftate 1% cream (antifungal)

Allergies:
☐ No Known Allergies
☐ To foods (list):

☐ To medications: (list):

☐ To the environment (insect stings, hay fever, etc.– list):

☐ Other allergies: (list):

Describe previous reactions:

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions:**(describe below)**

The camper is undergoing treatment at this time for the following conditions: (describe below)

Health History

Name: _____
First Middle Last

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. The camp requires original pharmacy containers with labels which show the camper's name and how the medication should be given. Parents need to provide enough of each medication to last the entire time the camper will be at camp.

Name of medication	Amount or dose given	How it is given	When it is given	Reason for taking it	Date started
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		

Inhaler / Epi-Pen authorization: Camper has Inhaler Epi-Pen (circle one) **with them and may self-administer.**
☐ Not Needed ☐ No ☐ Yes _____ (initials of health care provider)

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)						