 Day Camp Camper

 Health History Form

**Please follow the instructions (\*red asterisks\* notate mandatory information):**

1. **\*Complete all pages of this form and make a copy to keep for your records.**
2. **\*Send the original signed form to your church two weeks prior to your camper’s week of Day Camp.**

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

 First Middle Last

Dates will attend camp: from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Month/Day/Year) (Month/Day/Year)

\* Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Age\_\_\_\_\_\_\_\_\_ ❒ Male ❒ Female

 (Month/Day/Year)

Camper 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 Phones: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 Phones: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Allergies:**

❒ No known allergies.

❒This camper is allergic to: ❒ Food ❒ Medicine ❒ The environment (insect stings, hay fever, etc.)

❒ Other **(*Please describe below what the camper is allergic to and the reaction seen.)***

**\*Diet, Nutrition:**

❒ This camper eats a regular diet. ❒ This camper eats a regular vegetarian diet.

❒ This camper is lactose intolerant. ❒ This camper is gluten intolerant.

❒ Other, ***please explain in space***

**\*Medical Insurance Information:**

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

***Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.***

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

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Phone Number: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*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 congregational staff. I give permission to photocopy this form. In addition, the congregation 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 staff about my child’s health status. I acknowledge that all immunizations required for school are up to date.

Signature of Custodial Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Relationship to Camper: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Immunization History:** Provide the month and year for each immunization. Starred (\*) immunizations must include date. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Immunization | Dose 1Month/Year | Dose 2Month/Year | Dose 3Month/Year | Dose 4Month/Year | Dose 5Month/Year | Most Recent DoseMonth/Year |
| Diptheria, tetanus, pertussis(DTaP) or (TdaP) |  |  |  |  |  |  |
| Tetanus booster\*(dT) or (TdaP) |  |  |  |  |  |  |

If your camper has not been fully immunized, please contact you congregational leader.

**\*Medication:**

❒ This camper will not take any daily medication 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. ***Many states require original pharmacy containers with labels, which show the camper’s name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of medication | Date started | Reason for taking it | When it is given | Amount or dose given | How it is given |
|  |  |  | ❒ Breakfast❒ Lunch❒ Other time: |  |  |
|  |  |  | ❒ Breakfast❒ Lunch❒ Other time: |  |  |

**\*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 (“mono”) during the past 12 months?....

❒ Yes ❒ No

1. If female, have problems with periods/menstruation?....

❒ Yes ❒ No

1. Have problems with falling asleep/sleepwalking?….... ❒ Yes ❒ No
2. Ever had back/joint problem?….... ❒ Yes ❒ No
3. Have a history of bedwetting?….... ❒ Yes ❒ No
4. Have problems with diarrhea/constipation?….... ❒ Yes ❒ No
5. Have any skin problems?….... ❒ Yes ❒ No
6. Traveled outside the country in the past 9 months?….... ❒ Yes ❒ No

***Please explain “Yes” answers in the space below,*** noting the number of the questions. 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 congregational leader may contact you for additional information.

**\*Name of Camper’s Health-Care Providers:**

Primary doctor(s) or Healthcare facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist(s): ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Orthodontist(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What Have We Forgotten to Ask?**Please provide on the back of this page any additional information about the camper’s health that you think is important or that may affect the camper’s ability to fully participate in the camp program. Attach additional information if needed.