# HEALTH HISTORY FORM FOR CAMPERS

***PLEASE MAIL THIS FORM TO ADDRESS INDICATED ON INSTRUCTIONS BY MAY 1st. FORM TO BE COMPLETED BY PARENT/GUARDIAN.***

Name of Camper: _____ Sex: ☐ Female ☐ Male
(First / Middle / Last)

Birthdate: _____ Age Upon Arrival at Camp: _____ Dates attending Camp: From _____ to _____
(Month/Day/Year) (Month/Day/Year) (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: _____

E-mail: _____ Preferred Phone Number: (_____)_____

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 Number: (_____)_____ Additional Phone Number: (_____)_____

Additional Contact in event parent(s)/guardian(s) cannot be reached:

Name:_____ Relationship to Camper: _____

Preferred Phone Number: (_____)_____ Additional Phone Number: (_____)_____

## Allergies:

_____ No known allergies.

_____ Camper has an allergy to: ☐ Food ☐ Medicine ☐ Environment (insect stings, hay fever, etc.) ☐ Other

Please describe what the camper is allergic to and the reaction seen:

_____

## Diet/Nutrition:

This Camper ☐ Eats a Regular Diet ☐ Eats a Regular Vegetarian Diet ☐ Has Special Food Needs

Please describe:

_____

## Restrictions:

_____ I have reviewed the program and activities of the camp and feel the Camper can participate without restrictions.

_____ I have reviewed the program and activities of the camp and feel the Camper can participate with the following restrictions or adaptations. Please describe:

_____

## 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 so information is readable.**

Insurance Company: _____ Policy Number: _____

Subscriber: _____ Insurance Company Phone Number: (_____)_____

Camper Name: _____ Birthdate: _____
First Middle Last Month/Day/Year

## 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 injections, 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.

Subscriber: _____ Insurance

Camper is covered by family medical/hospital insurance ☐ Yes ☐ No

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

## Immunization History:

Please provide the dose, month and year for each immunization. It is not necessary to complete this section if you provide a copy of the official immunization history, obtained from your doctor.

Diptheria, tetanus, pertussis (DTaP) or (TdaP) Most Recent Dose/ Month/Year _____

Tetanus booster (dT) or (TdaP) Most Recent Dose/Month/Year _____

Mumps, measles, rubella (MMR) Most Recent Dose/ Month/Year _____

Polio (IPV) Most Recent Dose/ Month/Year _____

Haemophilus influenzae type B (HIB) Most Recent Dose/ Month/Year _____

Pneumococcal (PCV) Most Recent Dose/ Month/Year _____

Hepatitis B Most Recent Dose/ Month/Year _____

Hepatitis A Most Recent Dose/ Month/Year _____

Varicella (chicken pox) Most Recent Dose/ Month/Year _____ Or, had chicken pox? Date: _____

Meningococcal meningitis (MCV4) Most Recent Dose/ Month/Year _____

Tuberculosis (TB) test Date _____ ☐ Positive ☐ Negative

## Medication:

_____ This Camper will not take any daily medications while attending camp.

_____ This Camper will take the following daily medication(s) while at camp. This includes vitamins & natural remedies. Wekiva Youth Camp requires original pharmacy containers with labels which show the Camper's name and how the medication should be given. Provide enough medication to last the entire time the Camper will be at camp. All insect bite remedies should also be presented to the nurse at check-in.

Please provide Name of Medication; Date Started; Reason for Taking It; When Given; Amount or Dose Given; How Medication is Given:

_____

_____

_____

Camper Name: _____ Birthdate: _____
First Middle Last Month/Day/Year

## Non-Prescription Medication:

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. Please CROSS OUT those that the Camper should NOT be given.

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Sore throat spray
- Generic cough drops
- Calamine lotion
- Aloe
- Antibiotic cream
- Phenylephrine decongestant (Sudafed PE)
- Pseudoephedrine decongestant (Sudafed)
- Antihistamine/allergy medicine
- Guaifenesin cough syrup (Robitussin)
- Diphenhydramine antihistamine/allergy medicine (Benadryl)
- Dextromethorphan cough syrup (Robitussin DM)
- Lice shampoo or cream (Nix or Elimite)
- Laxatives for constipation (Ex-Lax)
- Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

## General Physical History:

*If you answer "Yes" to any of these questions, provide more information at the end of this section.*

1. Has the Camper ever been hospitalized or had surgery? ☐ Yes ☐ No
2. Does the Camper have recurrent/chronic illnesses? ☐ Yes ☐ No
3. Has the Camper had a recent infectious disease or recent injury? ☐ Yes ☐ No
4. Has the Camper had asthma/wheezing/shortness of breath? ☐ Yes ☐ No
5. Does the Camper have diabetes? ☐ Yes ☐ No
6. Has the Camper had seizures or headaches? ☐ Yes ☐ No
7. Does the Camper wear glasses, contacts of protective eyewear? ☐ Yes ☐ No
8. Has the Camper had fainting or dizziness? ☐ Yes ☐ No
9. Has the Camper passed out/had chest pain during exercise? ☐ Yes ☐ No
10. Has the Camper had mononucleosis ("mono") during the last 12 months? ☐ Yes ☐ No
11. If female, does the Camper have problems with periods/menstruation? ☐ Yes ☐ No
12. Does the Camper have problems with falling asleep/sleepwalking? ☐ Yes ☐ No
13. Has the Camper ever had back/joint problems? ☐ Yes ☐ No
14. Does the Camper have a history of bedwetting? ☐ Yes ☐ No
15. Does the Camper have problems with diarrhea/constipation? ☐ Yes ☐ No
16. Does the Camper have any skin problems? ☐ Yes ☐ No
17. Has the Camper traveled outside the country in the last 9 months? ☐ Yes ☐ No
18. Does the Camper have any history of exposure to communicable disease? ☐ Yes ☐ No

Please explain all YES answers, noting the number of questions. For travel outside the country, please name countries and dates of travel:

_____

_____

_____

In the case of exposure to a communicable disease, flu or lice within the two weeks prior to coming to camp, please contact the Camp Chairman.

## Mental, Emotional, & Social Health:

*If you answer "Yes" to any of these questions, provide more info at the end of this section.*

1. Has the Camper ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐ Yes ☐ No
2. Has the Camper ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, has the Camper seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Has the Camper had a significant life event that continues to affect the Camper's life (history of abuse, death of a loved one, family change, survived a disaster, foster care, etc) ☐ Yes ☐ No

Please explain all YES answers: _____

## Health Care Providers:

Name of primary physician: _____ Office Phone (_____)_____

Name of your dentist/orthodontist: _____ Office Phone (_____)_____

## Other Concerns:

_____

_____