CAMPER HEALTH HISTORY – CONFIDENTIAL Camper Name: _____

The following information must be completed for each camper.

Child's Physician _____ Phone _____ Date of last physical _____

Insurance Carrier _____ Identification # _____ Group # _____

Name of insured _____ Relationship to child _____

ALLERGIES TO: Describe reaction including severity and management:

- Medications _____ _____
- Food (nuts,eggs/dairy,?) _____ _____
- Insect stings _____ _____
- Environment _____ _____

MEDICATIONS:

Will your child be self-administering any medication while at camp? ☐ Yes ☐ No If yes:

Medication _____ Dose _____ How Often _____

Will you child be carrying any of the following? (check if carrying) Inhaler☐ Epi Pen☐ Insulin☐

********NOTE: If your child is self-administering medication while at camp, a copy of the doctor's prescription or order MUST be kept at camp in your child's file.********

Please list all medications that you child is currently taking at home. **Camp staff will not administer or store medications at the camp.**

Medication _____ Dose _____ How Often _____

Medication _____ Dose _____ How Often _____

Medication _____ Dose _____ How Often _____

Medication _____ Dose _____ How Often _____

IMMUNIZATIONS:

Provide a copy of your child's immunization record from your physician. NOTE: Please check "Copy of immunization record included:" if your copy of immunizations records clearly shows both the dates and ALL vaccines outlined below. A complete immunization series record is required for camp attendance. This camp's policy is that children need to be fully vaccinated in order to attend camp.

Immunization History - Attach a copy of child's immunization records and list the month/day/year administered below.

DPT Series	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	MMR	_/_/_	_/_/_
Tetanus/Diphtheria	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	or measles	_/_/_	_/_/_
Tetanus	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	or mumps	_/_/_	_/_/_
Polio OPV (Sabin)	_/_/_	_/_/_	_/_/_	_/_/_			or rubella	_/_/_	_/_/_
HIB Vaccine	_/_/_	_/_/_	_/_/_	_/_/_			Varicella	_/_/_	_/_/_
Hepatitis B	_/_/_	_/_/_	_/_/_				TB Mantoux Test	_/_/_	
Haemophilus Influenza B	_/_/_						TB Test Results	[ ] Positive	[ ] Negative

Copy of immunization record included: ☐

CIRCLE Y or N ANSWERS BELOW, IF "Y" PLEASE DESCRIBE

Wear glasses, contacts, or eye protection?	Y☐ N☐	Require ear plugs while swimming?	Y☐ N☐
Wear hearing aids?	Y☐ N☐	Have an eating disorder?	Y☐ N☐
Wear an orthodontic appliance?	Y☐ N☐	Have heart problems?	Y☐ N☐
Have asthma?	Y☐ N☐	Have skin problems?	Y☐ N☐
Have diabetes?	Y☐ N☐	Had recent mononucleosis?	Y☐ N☐
Have a seizure disorder?	Y☐ N☐	Have Hepatitis?	Y☐ N☐
Had a concussion?	Y☐ N☐	Had a severe allergic reaction?	Y☐ N☐
Have Sickle Cell disease or trait?	Y☐ N☐	Had Tuberculosis?	Y☐ N☐
Have a learning disorder or ADD/ADHD?	Y☐ N☐	Had frequent ear infections?	Y☐ N☐
Have depression or other emotional issues?	Y☐ N☐	Ever passed out?	Y☐ N☐

Does your child have any activity restrictions? ☐ Yes ☐ No If yes, please describe:

_____

Has your child traveled outside of the US in the last 30 days? ☐ Yes ☐ No If yes, where?

Any additional information about the participant's behavior and physical, emotional or mental health the camp should be aware of:

_____

PERMISSION TO PROVIDE NECESSARY FIRST AID OR EMERGENCY CARE:

☐ Yes ☐ No I hereby give permission to the camp director, or qualified camp counselor, or lifeguard to administer first aid to my child.

☐ Yes ☐ No In the event I cannot be reached in an emergency requiring immediate medical care, **I** hereby give permission to the camp director or designated camp counselors to call 911. This may result in transport by ambulance to a local hospital for the camp participant.

PREFERRED LOCAL HOSPITAL:

_____

I acknowledge that the information stated on this form is accurate and factual.

Parent/Guardian Signature:_____

Date: _____