

CAMPER HEALTH HISTORY FORM

CAMP SEALTH



DO NOT MAIL THIS!

Bring this health form with you when checking in on the first day of camp. If the camper is attending multiple sessions, only one form is required.

Camp Use Only

Health Screening (initial):

Notes:

Session:

Cslr:

Unit:

M.I.

First

Last

Name:

Camper's Name _____
Last First M.I.

Male Female Birthdate: ____ / ____ / ____ Grade this fall: ____

PARENT/GUARDIAN AUTHORIZATION and CONSENT TO TREAT

*If for any reason you wish **not** to authorize treatment, please attach a letter of explanation.*

I attest that my child (*child's name*) _____ is in good health and able to actively participate in camp activities except as noted in this form. I take full responsibility to see that my child is properly prepared for camp including having proper clothes and equipment and being in good health.

I authorize the camp to provide routine health care, administer prescribed and over-the-counter medications that I am sending to camp, as well as any medications recommended by the camp's health care staff for various problems except as I have noted in this form. I authorize the camp to share information on this Health History document with selected camp staff (counselor, health care, inclusion staff, etc.) and professional health care providers on a need-to-know basis.

In case of medical emergency or need for medical treatment, after every reasonable effort has been made to contact me, the family physician or one of the alternates listed on this form or my child's Camp Registration form, I hereby give my permission to the physician secured by the camp to hospitalize, secure treatment for and order injection, anesthesia or surgery for my child named above. I authorize the camp to arrange and/or provide necessary related transportation for my child. I agree to be responsible for expenses incurred in the care and treatment of my child.

Signature of Parent/Legal Guardian _____

Print Name _____ Date _____

MEDICAL INSURANCE and PHYSICIAN INFORMATION

Insurance Company _____ Policy Number _____

Name of primary insured person _____

Name of camper's primary physician _____

Name of clinic/hospital _____

City & State _____ Phone (____) _____

PARENT/GUARDIAN CONTACT INFORMATION

Camper's Name _____
Last First M.I.

Parent/Guardian with legal custody to be contacted in case of emergency:

Name: _____ Relationship to Camper: _____

Home (____) _____ Work (____) _____ Cell (____) _____

Second parent/guardian to contact:

Name: _____ Relationship to Camper: _____

Home (____) _____ Work (____) _____ Cell (____) _____

Additional contacts in event parents cannot be reached:

Name: _____ Relationship to Camper: _____ Phone (____) _____

Name: _____ Relationship to Camper: _____ Phone (____) _____

Is there anyone in particular to whom your child must NOT be released?

Name: _____ Relationship to Camper: _____

CAMPER CHECK-OUT - *This section to be completed at check-out*

The person picking up the camper MUST be listed as either a parent or emergency contact on this form. Pick-up person is required to sign and show photo ID when picking up the camper.

Name of person picking up child: _____ Signature _____

ALLERGIES

Please list all known allergies, including reaction and treatment to be given:

- No known allergies
- Food allergies
- Medication
- Environmental/seasonal
- Other

DIET and NUTRITION

Please check all that apply, and give any specifics that will help the kitchen staff provide the best possible nutritional support for your child.

- Camper eats a normal diet
- Vegetarian
- Vegan
- Other (specify): _____
- Lactose Intolerant/dairy-free
- Gluten Intolerant/wheat-free
- PKU

HEALTH HISTORY

Does the camper have a history of any of the following? Check all that apply:

- Asthma
- Diabetes
- Sleepwalking
- Nightmares
- Bed wetting
- Hospitalization
- Surgery
- Chronic illness
- Mononucleosis
- Heart problems
- Migraines
- Seizures
- Recent injuries
- Physical disabilities
- Other (specify): _____

Please explain any items checked above:

Any restrictions on the camper's activity while at camp? If yes, please explain:

- Yes
- No

MENTAL & EMOTIONAL HEALTH

Has the camper been diagnosed or treated for any of the following?

- ADD
- Learning disability
- ODD
- Developmental disabilities
- AD/HD
- PTSD
- Eating disorder
- Anxiety
- OCD
- Depression
- Other psychiatric diagnosis (specify): _____

Please explain any items checked above:

Does the camper see a mental health professional? Yes No

Any home, family or other life experiences or circumstances that camp staff should know about? Please explain:

ANYTHING ELSE?

Is there anything else we should know about your child?

MEDICATIONS

List ALL medication the camper is bringing to camp, including vitamins, prescriptions and over-the-counter meds. All medication must have:

- Original pharmacy or manufacturer containers
- Child's name (meds belonging to a sibling or other family member are not accepted)
- Current date (expired meds are not accepted)
- Written directions from pharmacy or physician (parent instructions for prescription medications are not accepted)

Note: If your child takes medication during the school year, we highly recommend that he/she continues to take the medication during the summer and at camp.

Name of medication	Reason for taking medication	Amount or dose given	When it is given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> 4 p.m. <input type="checkbox"/> Dinner <input type="checkbox"/> 8 p.m.	
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> 4 p.m. <input type="checkbox"/> Dinner <input type="checkbox"/> 8 p.m.	
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> 4 p.m. <input type="checkbox"/> Dinner <input type="checkbox"/> 8 p.m.	
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			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> 4 p.m. <input type="checkbox"/> Dinner <input type="checkbox"/> 8 p.m.	

The following medications (or their generic equivalents) may be stocked in the camp Health Center and administered as needed. Cross out any medications that the camper should not be given:

Pain, Illness & Allergies

Tylenol or Aleve
 Ibuprofen
 Benadryl
 Sudafed
 Excedrin
 Chlor-trimeton
 Robitussin
 Loratadine (Claritin)
 Chloraseptic spray
 Cough drops/throat lozenges
 Herbal tea

Digestion/Upset Stomach

Tums
 Pepto Bismol
 Altoids/peppermint
 Kaopectate
 Milk of Magnesia
 Gatorade

Other

Epinephrine (Epi-pen for life-threatening emergencies only)
 Lice shampoo/cream

Topical/Skin Products

Insect repellant with or without Deet
 Sunscreen
 Aloe vera
 Calamine or Caladryl lotion
 Skin moisturizer
 Baking soda/meat tenderizer
 Hydrocortisone
 Antibiotic ointment
 Lidocaine jelly
 Gold Bond medicated powder
 Athlete's foot ointment/powder

MEDICAL EXAMINATION - Optional

We recommend, but do not require, that campers have a medical examination and physician's authorization within the last 24 months prior to camp. You may also attach a copy of a school or sports physical exam.

Physician's statement - I find the camper to be in good health and able to take part in outdoor activities at Camp Sealth with the following exceptions:

Physician's signature _____ Date of exam _____
 Print Name _____ Phone (_____) _____

IMMUNIZATIONS

Give the dates of the most recent immunization or booster, or attach a copy of official immunization record:

DTaP/TdaP: MMR: IPV: HIB: HPV:
 PCV: Hep A: Hep B: Varicella: Other:

Has camper had chicken pox? Yes No

