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Camp Heritage

Camper Health History & Medical Consent Form

Camper Name: _____ Camp Dates: _____ to _____
First Middle Last Month/Day/Year Month/Day/Year

Home Address: _____ Gender: _____
Street Address

_____ Birth Date: _____ Age: _____
City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Primary Phone: _____
(Circle) Cell/Home/Day/Other

Home Address: _____ Alt. Phone #1: _____
(If different from above) Street Address City State Zip Code (Circle) Cell/Home/Day/Other

Email Address: _____ Alt. Phone #2: _____
(Circle) Cell/Home/Day/Other

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Primary Phone: _____
(Circle) Cell/Home/Day/Other

Alt. Phone #1: _____ Alt. Phone #2: _____
(Circle) Cell/Home/Day/Other (Circle) Cell/Home/Day/Other

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

Name: _____ Relationship to Camper: _____ Primary Phone: _____
(Circle) Cell/Home/Day/Other

Alt. Phone #1: _____ Alt. Phone #2: _____
(Circle) Cell/Home/Day/Other (Circle) Cell/Home/Day/Other

Medical Insurance Information:

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

If yes, 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: _____

If your camper is NOT covered by medical insurance, please sign the following statement: I will be responsible for medical expenses incurred on behalf of my camper.

Signature of Custodial Parent/Guardian: _____ Relationship to Camper: _____ Date: _____

Immunizations

Are all required immunizations up to date?: ❑ Yes ❑ No Date of last tetanus (DPT/TD): _____

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: _____ Relationship to Camper: _____ Date: _____

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: _____ Relationship to Camper: _____ Date: _____

Camper Name:_____ Camp Session Attending:_____

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

Diet, Nutrition: Please describe below any special food needs the camper has. (i.e. food allergies, vegan diet)

Non-Prescription Medications: Non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. (i.e. Acetaminophen, Antibiotic crème, Antihistamine/allergy medicine, Benadryl, Calamine lotion, Cough syrup, Ibuprofen, Laxatives for constipation, Lice shampoo, Pepto-Bismol) ***List those the camper should NOT be given:***

Medication: Please list any medications the camper will take while they are attending camp. "Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. ***Please bring medications in 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

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

Yes	No	
❑	❑	Have a chronic or recurring illness or condition (i.e. diabetes, heart trouble, asthma, convulsive disorder)?
❑	❑	Had a recent infectious disease?
❑	❑	Had a recent injury requiring hospitalization or medical intervention?
❑	❑	Have any mental health concerns (i.e. depression, eating disorder)?
❑	❑	Have any physical restrictions?
❑	❑	Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?
❑	❑	If female, have problems with periods/menstruation?
❑	❑	Had a significant life event that continues to affect the camper's life?
❑	❑	Recently traveled internationally (last 3 months)?
❑	❑	Have a history of bedwetting?
❑	❑	Other (additional info about your camper's health that you think is important or that may affect camper's ability to fully participate in the camp program)

Please explain "Yes" answers in the space below, noting the number of the questions. ***Attach additional information if needed.***

For Camp Use Only

Screening has been conducted according to camp protocol and significant findings noted as follows:

A.	Any signs/symptoms of illness or injury upon arrival?	No	Yes as noted below
B.	History of exposure to communicable disease?	No	Yes as noted below
C.	Additions or corrections to information on this health history?	No	Yes as noted below
D.	Medication given to health-care staff?	No	Yes as noted below
E.	Any signs/symptoms of head lice?	No	Yes as noted below

Initial Screening:

Date/Time:_____

Nurse Initials & Signature:

_____

_____

_____

_____