Hog Island Audubon Camp
SEABIRD RESTORATION PROGRAM

Audubon

Coastal Maine Bird Studies Camp for Teens
Camper Confidential Health History Form

General Information **Please Print All Information** **Returning Camper** ☐

Camper Name: **Dates Attending Camp:**

DOB **Age on arrival at camp:** **M** ☐ **F** ☐

Home Address:

Home Phone: **Cell:** **Email address:**

Emergency Contact

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

Name: **Relationship:**

Address

Home Phone: **Cell:** **Email address:**

Second Parent/Guardian with legal custody to be contacted in case of illness or injury

Name: **Relationship:**

Address

Home Phone: **Cell:** **Email address:**

Additional Contact if Parent(s)/Guardian cannot be reached

Name: **Relationship:**

Address:

Home Phone: **Cell:** **Email address:**

Healthcare Providers

Primary Care Physician: **Office Phone:**

Dentist/Orthodontist: **Office Phone:**

Healthcare Insurance

Is camper covered by family healthcare insurance? ☐**Yes** ☐**No**

Insurance Company: **Insurance Company Phone:**

Certificate/Policy/ID#: **Group# (if applicable):**

Name of Policy Holder: **Phone:**

If appropriate, include a copy (both sides) of your insurance card so information is readable.

Allergies ☐ No Known Allergies ☐

Please list all allergies to prescription and non-prescription medications, food, bites, stings, shellfish, iodine, plants & animals, other:

Please describe the reaction and how it is managed:

Does child carry/use an Epi-pen? ☐ **Yes** ☐ **No**

Diet/Nutrition

☐ **Regular diet** ☐ **Vegetarian** ☐ **Gluten Free** ☐ **Vegan** ☐ **Lactose Intolerant** ☐ **Other**

Please be specific: ex. -No red meat, food allergies, strong food dislikes, etc.

Camper Name: _____

General Health History

Yes	No	Please check yes or no for each question. If yes, elaborate in the space provided or attach an additional sheet with further details.	
		Hospitalizations/Emergency Room visits in the past year?	
		Surgery/Serious injuries in past 5 years?	
		Recurrent/Chronic illness?	
		Cardiac conditions or Chest pain during exercise?	
		High Blood Pressure?	Treated with medication?
		Bleeding Disorder?	
		Neck, back, knee, shoulder, ankle, problems?	
		Skin conditions?	
		Asthma or other respiratory conditions?	
		Mononucleosis (in past 12 months)?	
		Experience headaches?	
		Problems with diarrhea/constipation?	
		Difficulty falling asleep?	
		Experience sleepwalking?	
		History of bedwetting?	
		Experience fainting or dizziness?	
		If female, problems with menstruation?	
		Wear glasses, contacts, or protective eyewear?	
		Diabetes; please indicate if insulin dependent	
		Seizure disorder?	Date of last seizure:
		Eating Disorder?	
		Depression/Anxiety?	
		Emotional or behavioral difficulties?	
		Attention Deficit Disorder (ADD) or Attention Deficit/Hyperactivity Disorder (ADHD)?	
		Learning Disabilities?	
		Autism Spectrum Disorder (Classic Autism, Asperger's Syndrome, etc.)?	
		Significant life event that continues to affect the camper's life? (history of abuse, death of parent, disaster, family change, etc.)	
		Exposed to contagious disease in the last 4 weeks?	
		Received medical care for a disease or condition in the past 3 months?	
		Traveled outside the US in the past 9 months?	

Camper Name: _____

Medications
Medications will be administered by designated camp staff.

Medication is any substance a person takes to maintain and/or improve their health.
This includes vitamins & natural remedies.

- All medications sent to camp ***MUST*** be in ***original containers*** bearing the pharmacy label, with the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the camper's name, name of prescribing practitioner, name of the medication, dosage, directions for use and cautionary statements (if any contained in such prescribed medication or required by law), and if tablets or capsules.
- **I**nhalers ***must*** be in their ***prescription labeled box.***
- Prescription medications will only be administered according to the prescription label instructions.
- Medication in pillboxes or unlabeled containers ***will not*** be accepted.
- Provide sufficient amount of each medication to last the duration of camp.

We must have a signed
"Approval for Camper to Carry and Self-Administer Emergency Medication including, but Not Limited to, an Asthma inhaler or an Epinephrine Pen."

☐ This camper will not take any medications while attending camp.

☐ This camper will take the following medication(s) while at camp.

Name of Medication	Dosage	Time	How Administered	Reason for Taking
		__ Breakfast __ Lunch __ Supper __ Bedtime __ Other		
		__ Breakfast __ Lunch __ Supper __ Bedtime __ Other		
		__ Breakfast __ Lunch __ Supper __ Bedtime __ Other		

Attach Additional Pages as Necessary

Audubon Camp Hog Island Bremen, Maine
Approval for Camper to Carry and Self-Administer Emergency Medication including, but Not Limited to, an Asthma inhaler, or Epinephrine Pen.
This form is to be completed *only* if camper is 17 years or younger.
Parent/Guardian Form

As the parent/guardian for: _____, I acknowledge that
Print Camper 's Name
_____ is permitted to have readily available (carry or
Print Camper's Name
possess outside of the regular supervision of the camp's health staff) and **self-administer** as medically necessary, during his/her time at Audubon Camp Hog Island. Circle all that apply or list other emergency/regularly scheduled medication or device:

Asthma Inhaler (list brand here): _____

Epinephrine Pen (Epi-Pen): _____

Other: (Please list)

1. _____ _____
Name of medication/device Reason for use

2. _____ _____
Name of medication/device Reason for use

3. _____ _____
Name of medication/device Reason for use

All medications sent to camp ***MUST*** be in ***original containers*** bearing the pharmacy label, with the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the camper's name, name of prescribing practitioner, name of the medication, dosage, directions for use and cautionary statements if any contained in such prescription or as required by law, and if tablets or capsules.

Audubon Camp Hog Island
Self-Administered Emergency Medication Policy

The purpose of this policy is to comply with Maine law* requiring a youth camp to have a written policy authorizing campers to self-administer emergency medication, including, but not limited to, an asthma inhaler or an epinephrine pen. It is the policy of Hog Island camps that:

A. A camper who self-administers emergency medication must have the prior written approval of the camper's primary health care provider and the camper's parent/guardian;

B. The camper's parent/guardian must submit written verification to the youth camp from the camper's primary health care provider confirming that the camper has the knowledge and the skills to safely self-administer the emergency medication in camp;

C. The youth camp health staff must evaluate the camper's technique to ensure proper and effective use of the emergency medication in camp; and

D. The emergency medication must be readily available to the camper (i.e., to be carried or possessed outside of the regular supervision of camp health staff).

*Title 22, Subtitle 2, Part 5, Chapter 562, Section 2496.

I have read the Hog Island Audubon Camp Hog Island's policy and confirm that the camper has the knowledge and the skills to have readily available and safely self-administer the indicated emergency medication in camp.

Name of Parent/Guardian (please print): _____

Parent/Guardian Signature: _____ Date: _____

Camper Name: _____

Immunization History: Provide the month and year for each immunization. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/ Year	Dose 2 Month/ Year	Dose 3 Month/ Year	Dose 4 Month/ Year	Dose 5 Month/ Year	Most Recent Dose Month/Year
Diphtheria, Tetanus, Pertussis* (DTaP) or (TdaP)						
Tetanus booster * (dT) or (TdaP)						
Mumps, Measles, Rubella * (MMR)						
Polio * (IPV)						
Haemophilus Influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐Had chicken pox Date: _____						
Meningococcal Meningitis (MCV4)						

If your child has not been fully immunized, please sign the following statement:

I understand and accept the risks to my child by not being fully immunized.

Parent/Guardian Signature: _____

Print Name: _____

Relationship to child: _____

Date: _____

What have we forgotten to ask? Please use this space to add any additional information that would be helpful to the camp staff for your child to have a successful camping experience.

Camper Name: _____

Please review the complete Health History information to be certain every question has been completed. The completed Health History information is required for participation in this Audubon Program.

It is possible to complete many Audubon programs with a variety of medical/psychological conditions, but Audubon must be aware of these conditions. Failure to disclose health history information as requested could result in serious harm to camper and other participants in the program.

The status of camper's participation will be determined after review of this form. In some cases further evaluation, including consultation with camper's health care provider, may be necessary.

Parent/Guardian Authorization for Health Care:

* This camper has permission to participate in all camp activities except as noted by me and/or an examining physician.
* I authorize National Audubon Society, Inc. ("Audubon") staff, volunteers or Audubon's autho rized designees, including, but not limited to, medical personnel, to render such treatment they consider advisable for my child's health.
* I authorize the physician selected by Audubon or its authorized designees 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 authorize the physician to hospitalize, secure proper treatment and order injections, anesthesia or surgery for my child.
* I authorize Audubon or its authorized designees to obtain a copy of my child's health record from healthcare providers who treat my child and these providers may discuss my child's health status with Audubon or its authorized designees.
* I authorize Audubon or its authorized designees to share the information on this form on a "need to know" basis within Audubon, with its authorized designees or with medical personnel rendering treatment to my child. Furthermore, I understand that Audubon may disclose the information on this form if required by law, regulation or court order.
* I authorize photocopying this form.
* I agree to pay all costs and expenses (including transportation) associated with my child's care.
* This health history is correct and accurately reflects the health status of the camper to whom it pertains.

Parent/Guardian Signature: _____

Print Name: _____

Relationship to Camper: _____ **Date:** _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver, which must be signed for attendance.

<Please sign and return by May 1st>

By Mail (must have original signatures):
Hog Island Program Manager, National Audubon Society, 159 Sapsucker Woods Rd. Ithaca, NY 14850

If form will arrive after May 5 th, mail to:
Hog Island Audubon Camp, 12 Audubon Rd, Bremen ME 04551