# CAMPER HEALTH HISTORY FORM

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

***Mail this form to the address below no later than May 1***

***Southampton Summer Day Camp***
***1459 2nd Street Pike***
***Southampton, PA 18966***

Camper Name: _____ (First) _____ (Middle) _____ (Last)

Camper will attend: ☐ All 8 Weeks ☐ First 4 Weeks ☐ Last 4 Weeks

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp: _____

***To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.***

1) ***Complete pages 1, 2 and 3 of this form and make a copy.***
2) ***Your physician must review pages 1, 2 and 3 of this form and complete and sign page 4 by the requested date.***
3) ***After it has been completed and signed by your child's health-care provider, return pages 1-4 to camp by the requested date.***

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: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

Home Address: _____ (If different from above) (Street Address) (City) (State) (Zip Code)

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

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

Name(s): _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

**Allergies:** ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
***(Please describe below what the camper is allergic to and the reaction seen.)***

**Diet, Nutrition:** ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet.
☐ This camper has special food needs. ***(Please describe below.)***

**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 below.)***

**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 of the card so information is readable.***

Insurance Company_____ Policy Number_____

Subscriber_____ Insurance Company Phone Number (_____) _____

**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 _____ 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.***



Camper Name _____ (First) _____ (Middle) _____ (Last) (For Camp Use) Cabin or Group _____ (For Camp Use) Session Code(s): _____

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Camper Name: _____ (First / Middle / Last)

Birth Date: _____ (Month/Day/Year)

**Immunization History:** Provide the month and year for each immunization. Starred (★) immunizations must be current. 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 |
|---|---|---|---|---|---|---|
| Diptheria, tetanus, pertussis★ (DTaP) or (TdaP) | | | | | | |
| Tetanus booster★ (dT) or (TdaP) | | | | | | |
| Mumps, measles, rubella★ (MMR) | | | | | | |
| Polio★ (IPV) | | | | | | |
| Haemophilus influenzae type B (HIB) | | | | | | |
| Pneumococcal (PCV) | | | | | | |
| Hepatitis B | | | | | | |
| Hepatitis A | | | | | | |
| Varicella (chicken pox) ☐Had chicken pox Date: | | | | | | |
| Meningococcal meningitis (MCV4) | | | | | | |

| Tuberculosis (TB) test | Date: | ☐ Negative | ☐ Positive |
|---|---|---|---|

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

**Medication:** ☐ This camper will not take any daily medications while attending camp.

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

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require 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 |
|---|---|---|---|---|---|
| | | | ☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time: | | |
| | | | ☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time: | | |
| | | | ☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time: | | |

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. ***Cross out those the camper should not be given.***

Acetaminophen (Tylenol)
Tums
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Calamine lotion
Ibuprofen (Advil, Motrin)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

# CAMPER HEALTH HISTORY FORM

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Camper Name: _____ (First / Middle / Last)

Birth Date: _____ (Month/Day/Year)

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

Has/does the camper:

| | | | | | |
|---|---|---|---|---|---|
| 1. Ever been hospitalized? | ☐ Yes | ☐ No | 11. Had fainting or dizziness? | ☐ Yes | ☐ No |
| 2. Ever had surgery? | ☐ Yes | ☐ No | 12. Passed out/had chest pain during exercise? | ☐ Yes | ☐ No |
| 3. Have recurrent/chronic illnesses? | ☐ Yes | ☐ No | 13. Had mononucleosis ("mono") during the past 12 months? | ☐ Yes | ☐ No |
| 4. Had a recent infectious disease? | ☐ Yes | ☐ No | 14. If female, have problems with periods/menstruation? | ☐ Yes | ☐ No |
| 5. Had a recent injury? | ☐ Yes | ☐ No | 15. Have problems with falling asleep/sleepwalking? | ☐ Yes | ☐ No |
| 6. Had asthma/wheezing/shortness of breath? | ☐ Yes | ☐ No | 16. Ever had back/joint problems? | ☐ Yes | ☐ No |
| 7. Have diabetes? | ☐ Yes | ☐ No | 17. Have a history of bedwetting? | ☐ Yes | ☐ No |
| 8. Had seizures? | ☐ Yes | ☐ No | 18. Have problems with diarrhea/constipation? | ☐ Yes | ☐ No |
| 9. Had headaches? | ☐ Yes | ☐ No | 19. Have any skin problems? | ☐ Yes | ☐ No |
| 10. Wear glasses, contacts, or protective eyewear? | ☐ Yes | ☐ No | 20. Traveled outside the country in the past 9 months? | ☐ Yes | ☐ No |

***Please explain "Yes" answers in the space below,*** noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

**Mental, Emotional, and Social Health**: ***Check "Yes" or "No" for each statement.***

Has the camper:

| | | |
|---|---|---|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? | ☐ Yes | ☐ No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder? | ☐ Yes | ☐ No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns? | ☐ Yes | ☐ No |
| 4. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) | ☐ Yes | ☐ No |

***Please explain "Yes" answers in the space below,*** noting the number of the questions. The camp may contact you for additional information.

**Health-Care Providers:**

Name of camper's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ Phone: (_____) _____

**What Have We Forgotten to Ask?** ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. ***Attach additional information if needed.***

CAMPER HEALTH-CARE RECOMMENDATIONS
by LICENSED MEDICAL PERSONNEL

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

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***Southampton Summer Day Camp***
***1459 2nd Street Pike***
***Southampton, PA 18966***

***To Parent(s)/Guardian(s): After completing this section, please give all pages to your child's health-care provider for review and signature.***

Camper Name: _____ (First) _____ (Middle) _____ (Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp _____

Camper home address: _____

_____ (City) _____ (State) _____ (Zip Code)

Custodial parent(s)/guardian(s) phone: (_____)_____ (_____)_____

***Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.***

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Medical personnel: Cross out those items the camper should not be given.***

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Tums
Diphenhydramine (Benadryl)
Generic cough drops
Calamine lotion
Bismuth subsalicylate (Pepto-Bismol)
Hydrocortisone 1% cream
Topical antibiotic cream
Calamine lotion
Aloe

***Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (Pages 1-3) and complete all remaining sections of this form (Page 4). Attach additional information if needed.***

**Physical exam done today:** ☐ Yes ☐ No (If "No," date of last physical: _____ (Month/Day/Year))

**ACA accreditation standards specify physical exam within last 24 months.**

Weight: _____ lbs Height: _____ft_____in Blood Pressure_____/_____

**Allergies:** ☐ No Known Allergies

☐ To foods ***(list):***

☐ To medications: ***(list):***

☐ To the environment ***(insect stings, hay fever, etc.– list):***

☐ Other allergies: ***(list):***

***Describe previous reactions:***

**Diet, Nutrition:** ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions:***(describe below)***

**The camper is undergoing treatment at this time for the following conditions:** ***(describe below)*** ☐ None.

**Medication:** ☐ No daily medications. ☐ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe below)***

**Other treatments/therapies to be continued at camp:** ***(describe below)*** ☐ None needed.

**Do you feel that the camper will require limitations or restrictions to activity while at camp?** ☐ No ☐ Yes

***If you answered "Yes"*** to the question above, what do you recommend? ***(describe below—attach additional information if needed)***

**"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)**

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Telephone: (_____)_____ Date: _____

Camper Name _____ (First) _____ (Middle) _____ (Last) (For Camp Use) Cabin or Group _____ (For Camp Use) Session Code(s): _____



Rev. 2/07 LEE/EAW