

CAMPER HEALTH HISTORY FORM 1

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

Dates will attend camp from _____ to _____
Camper Name: _____

Male Female Birth Date _____
Age on arrival at camp: _____

Fax to UCCR Office At:
707/762-3164 by 6/11/08
Attn: Kathryn Gross

To Parent(s)/Guardian(s): Please follow the instructions below.

- 1) Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.
- 2) Send the original, signed FORM 1 to camp by the requested date.
- 3) Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide copy of FORM 1 with FORM 2 to your child's health-care provider for completion.
- 4) After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.

Camper Home Address: _____

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

Name: _____ Relationship to Camper _____ Preferred Phone: _____

Home Address: (if different from above) _____

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper _____ Preferred Phone: _____

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

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

Allergies: No Known Allergies This camper is allergic to: Food Medicine
 The environment (insect stings, have 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: **Include a copy of your insurance card if appropriate; copy both sides of the card please**

This camper is covered by family medical/hospital insurance Yes No Insurance Company _____
Policy Number _____ Subscriber _____ Insurance Company Phone _____

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.

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Camper Name: _____

Birth Date: _____

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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
Diphtheria, 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 <input type="checkbox"/> had chicken pox (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
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		

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Birth Date: _____

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

Has/does the camper:

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

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

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.**

Parents/Guardians: STOP here. The rest of this form is completed when the camper arrives at camp. Keep a copy for your records.

