Camper Health Form 2017

PLEASE NOTE: ONE FORM FRONT AND BACK PER CHILD MUST BE COMPLETED & RETURNED TO THE CAMP OFFICE *ALONG WITH A PHOTOCOPY OF THE FRONT AND BACK OF THE CHILD'S INSURANCE CARD*. NO CHILD WILL BE ALLOWED TO ATTEND CAMP WITHOUT THESE FORMS ON FILE! *VALID FROM MARCH 1, 2017 THROUGH FEBRUARY 28, 2018*

Child's Name_____ Birth Date _____**Age as of (6/1/17)**____**Grade(8/2017)**_____
Last First Middle

Camper Home Address:

_____
Street Address City State Zip Code

Gender: ☐ Male ☐ Female School Attending in the Fall_____

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

Business Address:

_____
Street Address City State Zip Code

Business Phone: (_____) _____

Second parent/guardian or other emergency contact:

Name:_____ Relationship to Camper: _____
Preferred Phones: (_____) _____(_____)_____
Email: _____
Home Address:

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

Business Address:

_____
Street Address City State Zip Code

Business Phone: (_____) _____

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

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

INSURANCE INFORMATION

Family Medical Insurance Carrier_____ Policy Holder's Name_____

Policy/Group #_____ ID #_____

DOCTOR INFORMATION

Name of family physician_____ Phone_____

Address_____

Name of family dentist/orthodontist_____ Phone_____

Address_____

CHILD'S NAME_____

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 is lactose intolerant. ☐ This camper is gluten intolerant.
☐ Other, ***please explain in space.***

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.)

MEDICATIONS TAKEN BY CAMPER

Please list *ALL* medications (including over-the-counter or prescription) taken routinely**. <u>If the medication(s) need to be taken at camp</u>**, please complete a Medication Administration Permission form and send it to the Camp Office along with enough medication for the length of the child's camp. ***We require original pharmacy containers with labels which show the camper's name and how the medication should be given.***

☐ This person **takes no medications** on a routine basis. **OR** ☐ This person **takes medication** as follows:

Med #1_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Med #2_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Identify any medications taken during the school year that participant does/may not take during the summer:
_____

GENERAL QUESTIONS (Explain "yes" answers on a separate sheet of paper)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury or illness?	☐	☐	16. Ever had back problems?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐	17. Ever had problems with knees or ankles?	☐	☐
3. Ever been hospitalized?	☐	☐	18. Have an orthodontic appliance being brought to camp.	☐	☐
4. Ever had surgery?	☐	☐	19. Have any skin problems? (itching, rash, etc.)	☐	☐
5. Have frequent headaches?	☐	☐	20. Have diabetes?	☐	☐
6. Ever had a head injury?	☐	☐	21. Have asthma?	☐	☐
7. Wear glasses, contracts or protective eyewear?	☐	☐	22. Had mononucleosis in the past 12 months?	☐	☐
8. Ever been knocked unconscious?	☐	☐	23. Had problems with diarrhea/constipation?	☐	☐
9. Ever had frequent ear infections?	☐	☐	24. Have problems with sleepwalking?	☐	☐
10. Ever passed out during or after exercise?	☐	☐	25. If female, have an abnormal menstrual history?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐	26. Have a history of bed-wetting?	☐	☐
12. Ever had seizures?	☐	☐	27. Ever had an eating disorder?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐	28. Ever had emotional difficulties for which professional help was sought?	☐	☐
14. Ever had high blood pressure?	☐	☐			
15. Ever been diagnosed with a heart murmur?	☐	☐			

CHILD'S NAME_____

Immunization History:
I attest that my camper has been fully immunized, based on the school attendance requirements by The Commonwealth of Kentucky and are up to date.
Signature of Custodial Parent/Guardian: _____Date:_____ Relationship to Camper: _____

Provide the month and year for most recent Tetanus booster (dT) or (TdaP) _____
(must include date to meet ACA Standard)

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: _____

Camper has had the following diseases – Check all that apply:
☐ Measles ☐ Chicken Pox ☐ German Measles ☐ Mumps ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware.
_____
_____
_____

We will not administer non-prescription medications without a prescription from a physician on file. Should your child become ill or receive an injury during camp, however, we do have the following non-prescription medications stocked in the camp Office:
Acetaminophen (Tylenol)
Calamine lotion
Antibiotic cream
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Ibuprofen (Advil, Motrin)
Aloe
A member of the Office or Supervisory Staff will call you or your identified emergency contact to assess the situation, determine if camper needs to be picked up or receive permission to administer medication.

PLEASE ATTACH A PHOTOCOPY OF THE FRONT AND BACK OF THE CHILD'S INSURANCE CARD TO THIS FORM AND RETURN IT TO THE CAMP OFFICE.

PARENT/GUARDIAN AUTHORIZATIONS:

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportations for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician/nurse selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian_____ Date_____