

Camp Health History Form For Campers & Staff

Return this form by May 15 to Summer Trails, Box C, Granite Springs, NY 10527, 914-245-1776

Camper Name _____ **Birth Date** _____ **Age at Camp** _____ **Gender** _____

Parent/Guardian/Spouse Name:

Home Address _____ City _____ State _____ Zip _____ Phone _____

Business Address _____ City _____ State _____ Zip _____ Phone _____

Second Parent/Guardian Emergency Contact Name:

Home Address _____ City _____ State _____ Zip _____ Phone _____

Business Address _____ City _____ State _____ Zip _____ Phone _____

If not available in an emergency, notify:

Relationship _____ Phone _____

Home Address _____ City _____ State _____ Zip _____ Phone _____

Name of Family Physician:

Address _____ City _____ State _____ Zip _____ Phone _____

Name of Family Dentist/Orthodontist:

Address _____ City _____ State _____ Zip _____ Phone _____

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____

Prescribed Medications Being Taken

Please list ALL medications (over-the-counter & non-prescription drugs) taken routinely (during the camp day & at home). Prescription medications that are taken during the camp day should be kept in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration. Attach additional pages for more medications.

This person takes NO medications on a routine bases. OR This person takes medications 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.

Provide information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware. Attach additional page if needed. _____

Important- This box must be completed for attendance

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 authorize Summer Trails Day Camp Inc. to administer the Standard Over the Counter/PRN Medications named in this document as indicated by my child's healthcare provider to the above named if necessary.

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 treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician 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 or adult staff member: _____

Print Name _____ Date _____

NAME

Immunization History

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test if indicated
 Date of last test _____
 Result: Positive Negative

Please give all dates of immunization for:

Vaccine	Dates	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMRV		_____	_____	_____	_____	_____	_____
or measles		_____	_____	_____	_____	_____	_____
or mumps		_____	_____	_____	_____	_____	_____
or rubella		_____	_____	_____	_____	_____	_____
or varicella		_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____

Health Examination by Licensed Physician

I have examined the above applicant. Date Examined: _____

In my opinion, the above applicant is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following condition(s):

Current treatment: _____

Explanation of any reported loss of consciousness, convulsion, or concussion: _____

Does applicant have epilepsy? Yes No Does applicant have diabetes? Yes No

Recommendations and Restrictions while at camp: _____

Any treatment to be continued at camp: _____

Any medically prescribed meal plan or dietary restrictions: _____

Any allergies (food, drugs, plants, insects, etc) and state reaction: _____

Additional information for health care staff at the camp: _____

Standard Over the Counter/PRN Medications/ Epi-Pen & Albuterol

The first four medications are available in the infirmary and will be administered at the discretion of a RN, if approval is indicated by the camper's healthcare provider. If your child has been prescribed an epi-pen or albuterol, doctor's orders must be written below in addition to submitting the medication with the appropriate label.

Drug Name	Circle Preferred Route	Dosage	Schedule/Indication	Physician's Order
Tylenol	PO/chewable, elixir or tabs	Per Label Age/Weight	Q4 hr prn pain/fever > ___F	Yes No
Ibuprofen	PO/chewable, elixir or tabs	Per Label Age/Weight	Q6 hr prn pain/fever > ___F	Yes No
Visine		Per Label Age	1-2 drops up to 4x day	Yes No
Benadryl		Per Label Age/Weight	5mg/kg/24hrs	Yes No
Epi-Pen				
Albuterol				

Licensed Physician's Signature	Phone
Address	
Date of Form Completion	Name of person completing form