

MENTAL, EMOTIONAL AND SOCIAL HEALTH

Check all that apply:

- Attention Deficit Disorder (ADD)
 ADHD
 Hyperactivity
 Learning Disability
 Emotional health concern
 Psychiatric diagnosis: _____
 Other _____

Describe severity and management plan (attach separate sheet if necessary) _____

Name and telephone number of physician treating this (these) diagnosis: _____

MEDICATIONS

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

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 _____

RESTRICTIONS

The following restrictions apply to this individual:

- DIETARY:**
- Does not eat red meat
 Does not eat pork
 Does not eat eggs
 Does not eat poultry
 Does not eat seafood
 Does not eat dairy products
 Other _____

ACTIVITIES: Explain any restrictions to activities (e.g. what cannot be done, what adaptations or limitations are necessary).

INFECTIONS DISEASES AND IMMUNIZATIONS

Which of the following has the participant had?

- Measles
 Chicken pox
 German measles
 Mumps
 Hepatitis A
 Hepatitis B
 Hepatitis C
 TB Mantoux Test
 Date of last test _____
 Result: Positive Negative

Please give all dates of immunization or attach a copy of immunization record:

Vaccine:	Dates:	Mo / Yr	Mo / Yr	Mo / Yr	Mo / Yr	Mo / Yr	Mo / Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____	_____
Or Mumps		_____	_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____	_____
Maemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

GENERAL QUESTIONS

Has/does the participant:

- | | | |
|--|--|--|
| 1. Had any recent injury, illness or infectious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have a chronic or recurring illness/condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Ever had a head injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Ever been knocked unconscious? <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Wear glasses, contacts or protective eye wear? <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Ever had frequent ear infections? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Ever passed out during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Ever been dizzy during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No

12. Ever had seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No
13. Ever had chest pain during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Ever had high blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Ever been diagnosed with a heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No
16. Ever had back problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
17. Ever had problems with joints (e.g. knees, ankles)? <input type="checkbox"/> Yes <input type="checkbox"/> No
18. Have an orthodontic appliance being brought to camp? <input type="checkbox"/> Yes <input type="checkbox"/> No
19. Have any skin problems (e.g. itching, rash, acne)? <input type="checkbox"/> Yes <input type="checkbox"/> No
20. Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No
21. Have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No
22. Had mononucleosis in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
23. Had problems with diarrhea/ constipation? <input type="checkbox"/> Yes <input type="checkbox"/> No
24. Have problems with sleepwalking? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. If female, have an abnormal menstrual history? <input type="checkbox"/> Yes <input type="checkbox"/> No
26. Have a history of bed-wetting? <input type="checkbox"/> Yes <input type="checkbox"/> No
27. Have had an eating disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
28. Ever had emotional difficulties for which professional help was sought? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
|--|--|--|

If you answered "yes" to any of the above questions, please explain severity, treatment and care:

AUTHORIZATION FOR OVER-THE-COUNTER MEDICATIONS

Following are the over-the-counter medications we use for common ailments that arise at camp. These are recommended by the physician/nurse practitioner who oversees health care at camp. We are limited to dispensing only these medications without further permission from a physician or parent/guardian.

CHECK HERE TO GIVE PERMISSION FOR THE CAMP TO ADMINISTER THE FOLLOWING IF DEEMED NECESSARY. FEEL FREE TO CROSS OUT ANY PRODUCTS THAT YOU DO **NOT** WANT YOUR CHILD TO HAVE.

For pain, cough, cold:

For digestive upsets:

Topical (skin) products:

Tylenol or Aleve

Tums (or similar antacids)

Insect repellent (with DEET)

Ibuprofen

Pepto Bismol

Chigger powder (contains sulfur)

Benadryl

Altoids or peppermint

Sunscreen

Chlor-Trimeton

Kaopectate

Aloe Vera plant or gel

Robitussin

Milk of Magnesia

Calamine or caladryl lotion

Sudafed

Skin moisturizer (Avon Skin So Soft)

Chloraseptic spray

1% hydrocortisone cream

Cough drops / throat lozenges

Antibiotic ointment

Herbal tea

2% lidocaine jelly or spray

Hydrogen peroxide

To help us determine medication dosages, please give:

Child's age this summer: _____

Height: _____

Weight: _____ pounds

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.

PHYSICIAN INFORMATION

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

PARENT'S CAMPING AUTHORIZATION AND CONSENT TO TREATMENT

If for religious or other reasons you wish to withhold authorization for treatment, please attach a letter of explanation.

I attest that my child (child's name) _____ is in good health and able to actively participate in camp activities except as noted in this form. I take full responsibility to see that my child is properly prepared for camp including having proper clothes and equipment and being in good health.

I authorize the camp to provide routine health care, administer prescribed and over-the-counter medications that I am sending to camp, as well as any medications recommended by the camp's physician/nurse practitioner for various problems except as I have noted above. I authorize the camp to share information in this 4-page Health History document with selected camp staff (counselor, health care and inclusion staff, food services supervisor, etc.) and professional health care providers on a need-to-know basis.

In case of medical emergency or need for medical treatment, after every reasonable effort has been made to contact me, the family physician or one of the alternates listed on my child's registration, I hereby give my permission to the physician/nurse practitioner/registered nurse secured by the camp to hospitalize, secure treatment for and to order injection, anesthesia or surgery for my child named above. I authorize the camp to arrange and/or provide necessary related transportation for my child.

I agree to be responsible for expenses incurred in the care and treatment of my child.

Health Insurance Company _____ Name of primary insured person _____

Policy/Group No. _____ Telephone Nos. _____

Signature of Parent/Legal Guardian **X** _____ Date _____

Print Name _____ Relationship to child _____