



**Brethren
Woods**

CAMPER Health History Form

Camper Name: _____
First Middle Last

Preferred Name: _____ Dates of Camp(s): _____

Birth Date: _____ Age at Camp: _____

Male
 Female

Area/Group (for camp use only): _____

DIRECTIONS:

1. Please complete pages 1-3 of this form as accurately as possible and **BRING IT WITH YOU** when you come to camp.
2. Attach a copy of **BOTH SIDES** of your insurance card, if appropriate.
3. Be sure to bring all medications listed with you to camp in their **ORIGINAL CONTAINER** with the **ORIGINAL LABEL**.

Contact Information

Home Address: _____
Street City State Zip Code

Phone Number(s): Cell _____ Home _____ Work _____

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

Name: _____ Relationship to Camper: _____

Preferred Phone Number(s): Cell _____ Home _____ Work _____

Email Address: _____

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

Second Parent/Guardian to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____

Preferred Phone Number(s): Cell _____ Home _____ Work _____

Emergency Contact if parents/guardians cannot be reached:

Name: _____ Relationship to Camper: _____

Preferred Phone Number(s): Cell _____ Home _____ Work _____

Health Care Providers

Name of Primary Doctor/Practice: _____ Phone Number: _____

Name of Dentist(s): _____ Phone Number: _____

Name of Orthodontist(s): _____ Phone Number: _____

Medical Insurance Information – Attach a copy of BOTH SIDES of your insurance card, if appropriate.

- This camper is NOT covered by family medical/hospital insurance.
- This camper IS covered by family medical/hospital insurance. **Describe below.**

Insurance Company: _____ Phone Number: _____

Subscriber: _____ Policy Number: _____

Acknowledgement and 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. I understand that first aid supplies and equipment, including an AED, are available on-site at camp. I give permission to the camp healthcare provider(s) to provide routine health care, including administering medications. The camp generally does not contact parents/guardians or emergency contacts if campers are seen by the camp healthcare provider for routine problems (e.g., skinned knees, sore throat, headache) that do not require a physician referral. This includes overnight stays in the health center. The decision to consult parents/guardians or emergency contacts in these situations is determined on a case-by-case basis by our healthcare provider. I understand I must attach a letter to this form if I want the camp to follow a practice different from what is described. In case of an emergency, the camp healthcare provider will make every effort to contact parents/guardians or emergency contacts by phone, using the numbers provided on this form, if the camper listed has need for out-of-camp healthcare, but the camp cannot promise that it will be successful in reaching these persons. If these persons cannot be reached in an emergency, I give permission to the physician selected by the camp to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this camper. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of me or my child for both routine health care and emergency situations. I give permission to the camp to arrange necessary related transportation for me or my 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 me or my child’s health record from providers who treat me or my child and these providers may talk with the camp staff about my or my child’s health status.

Signature of Custodial Parent/Guardian or Adult Camper: _____

Relationship to Camper: _____ Date: _____

General Health History – Circle YES or NO for each statement. Explain any YES answers in the space 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 problematic 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 any YES answers in the space below, noting the question number. For seizures, give date of last seizure and describe seizures (duration, aura, etc.) For travel outside the country, list dates and countries visited. Attach sheets with additional information if needed.

Immunization History

In order to protect the entire camp community, we strive to have the highest possible level of fully immunized campers and staff. The Center for Disease Control, Commonwealth of VA, and American Camp Association recommend that all school age and older campers and staff have at least the following immunizations:

- Mumps, Measles, Rubella (MMR) - 2 doses
- Polio (IPV) - 4 doses
- Hepatitis B (Hep B) - 3 doses
- Varicella/Chicken Pox - 2 doses or evidence of having the disease
- **Diphtheria, Tetanus, Pertussis (DTaP, TdaP, DTP, DT) - 4 doses**
Date of last Tetanus booster: Month _____ Year _____

Please indicate your camper/staff level of immunization below and attach a copy of any available immunization record, including dates, to verify this information. Be sure to record the date of the last Tetanus shot above.

- YES, this camper is FULLY immunized as described above. **Please attach immunization record to verify.**
- NO, this camper is NOT fully immunized as described above. I understand this creates risks for me/my child including potential exposure to severe illness and the need to leave camp early in the case of unknown illness to avoid endangering others. **Please attach any available immunization record.**

Allergies – Persons with food allergies should complete a Food Allergy & Special Diet Questionnaire for our Food Service Staff.

- No known allergies.
- Allergies to food, medicine, environment (insect stings, hay fever, etc.), or other. **Describe in detail below.**

Allergen	Severity and Time Till Reaction	Reaction Experienced	Management Required	Ability of Camper to Manage Allergy & Threats

Diet/Nutrition – Persons with intolerances should complete a Food Allergy & Special Diet Questionnaire for our Food Service Staff.

- Eats a regular diet.
- Eats a regular vegetarian diet.
- Eats a diabetic diet.
- Lactose intolerant.
- Gluten intolerant.
- Other diet. **Describe in detail below.**

Activity 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. **Describe in detail below. Attach sheets with additional information if needed.**

Mental, Emotional, and Social Health – Circle YES or NO for each statement. Explain any YES answers in the space below.

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 their life?
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.) | YES | NO |

Please explain any YES answers in the space below, noting the question number. Attach sheets with additional information if needed.

Health Center Medications – Please cross out any items that the camper should NOT be given.

The following non-prescription medications (name brand or generic) MAY be stocked in the camp Health Center and are available for use on an as needed basis to manage illness and injury. Campers DO NOT need to bring these medications with them to camp unless prescribed and/or needed for regular use.

- | | |
|--|--|
| Acetaminophen (Tylenol) / Ibuprofen (Advil, Motrin) | Pseudoephedrine decongestant (Sudafed) |
| Phenylephrine decongestant (Sudafed PE, Cold/Sinus) | Guaifenesin cough syrup (Robitussin, Robitussin CF) |
| Antihistamine/allergy medicine | Dextromethorphan cough syrup (Robitussin DM) |
| Diphenhydramine antihistamine/allergy medication (Benadryl) | Generic cough drops |
| Sore throat spray | Antibiotic cream |
| Calamine lotion (Caladryl) | Hydrocortisone cream |
| Laxatives for constipation (Milk of Magnesia, Ex-Lax, suppositories) | Aloe, Aloe vera |
| Antacid (Tums) | Bismuth subsalicylate for diarrhea (Imodium, Pepto-bismol) |
| Zanfel for poison ivy | Midol |
| Epi-Pen (regular, junior) | Sunscreen |

Camper Medications – A “medication” is any substance a person takes to maintain and/or improve their health. This includes prescription and over-the-counter substances, including vitamins and natural/health remedies.

- This camper will NOT bring any medications to camp.
- This camper WILL bring the following medications to camp. *Attach sheets with additional information if needed. Be sure to bring all medications listed with you to camp in their ORIGINAL CONTAINER with the ORIGINAL LABEL showing the camper name, prescribing physician (if applicable), name of the medication, dosage, frequency, and how the medication is to be given.*

Medication Name	Date Started	Reason for Taking	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: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		

Anything Else? – Please provide any additional information in the space below that you think important or that may affect the time at camp for this camper. Attach sheets with additional information if needed.

