

Summer Day Camp Health History Form

**To Parent(s)/Guardian(s): Please follow the instructions below.
Attach additional information if needed.**

1. Complete front and back of this form and make a copy.
2. Send the original signed form to camp at least 10 days prior to camper's arrival.
3. Campers cannot be accepted for camp sessions without a signed health history.

Return this form to your Day
Camp Site Coordinator.

Camper Name _____
Last _____
First _____
Initial _____
(For Camp Use) Cabin or Group _____
(For Camp Use) Week/Camp _____

Camper Name: _____
Last First Init.

Gender: _____ Birth Date: _____ Grade Entering: _____ Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year Month/Day/Year

Camp Program/Location: _____

Camper Home Address: _____
Street Address City State Zip Code

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

Name: _____ Relationship to Camper: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____

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

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____

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

Name: _____ Relationship to Camper: _____ Home/Cell Phones: (____) _____ (____) _____

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 has special food needs. *(Please describe below.)*

Activity Restrictions: Chronic illness, operations, or serious injury. *(Please describe below.)*

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

Has/does the camper:

- | | |
|---|---|
| 1. Had frequent ear infections? <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Had mononucleosis ("mono") during the past 12 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have a heart defect or heart disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. If female, have problems with periods/menstruation..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Had seizures or convulsions? <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. If female, has been told about menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have a bleeding/clotting disorder?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Have problems with falling asleep/sleepwalking? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Had hypertension?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Have a history of bedwetting? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Had Chicken Pox? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had Psychiatric Treatment?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Had Measles?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Have headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Had Mumps? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Had German Measles?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Have diabetes? (year) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Please explain "Yes" answers in the space below, noting the number of the questions.

Summer Day Camp Health History Form

	Camper Name: _____	First _____ Init. _____
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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 camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)..... Yes No

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Immunization Record:

Date of Last Tetanus _____ DPT _____ Polio _____ MMR _____

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 attending camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Day Camp counselors will not administer prescribed medication (unless emergency inhaler, epi-pen etc.) only over the counter medication as needed.

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: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those the camper should not be given.**

Acetaminophen (Tylenol)	Phenylephrine decongestant (Sudafed PE)	Calamine lotion
Ibuprofen (Advil, Motrin)	Pseudoephedrine decongestant (Sudafed)	Antibiotic cream
Antihistamine/allergy medicine	Guaifenesin cough syrup (Robitussin)	Aloe
Diabetes medicine (insulin)	Diabetes medicine (Robitussin DM)	Band-Aid Ant-Itch Gel (45% benzocaine)

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: () _____

Medical Insurance Information: This camper is covered by family medical/hospital insurance Yes No

Please include a copy of your insurance card; copy both sides of the card so information is readable.

Insurance Company _____ Policy or ID # _____ Group Plan # _____
 Subscriber _____ Insurance Company Phone Number () _____ Where insured is employed _____
 Address for claims _____

Check here if you do **NOT** give permission for A&KB Ministries to photograph your child for camp promotional purposes (brochures, SmugMug, etc.) No names are used.

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: _____

What Have We Forgotten to Ask?

Please attach 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.