



# CAMPER HEALTH HISTORY FORM

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Dates will attend camp: from \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Camper Name: \_\_\_\_\_  
First Middle Last

Male  Female Birth Date \_\_\_\_\_ Age on arrival at camp: \_\_\_\_\_

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: \_\_\_\_\_

Preferred Phones: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Home Address:

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

Second parent/guardian or other emergency contact:

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Preferred Phones: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

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

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Preferred 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.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Restrictions:**  I have reviewed the program and activities of the camp and feel the camper can participate without restrictions. I agree that the camp or its staff will not be held responsible for accidents or personal injury arising there from.

I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. I agree that the camp or its staff will not be held responsible for accidents or personal injury arising there from. *(Please describe below.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I grant permission for my child's photo to be used in camp publications.  Yes  No

**Medical Insurance Information:**

This camper is covered by family medical/hospital insurance  Yes  No

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Subscriber \_\_\_\_\_ Insurance Company Phone Number (\_\_\_\_) \_\_\_\_\_

Camper Name \_\_\_\_\_  
First Middle Last

**Immunization History:** Please check the box for each immunization your child has received:

- |  |  |
|--|--|
| <input type="checkbox"/> Diphtheria, tetanus, pertussis (DTaP) or (TdaP) | <input type="checkbox"/> Hepatitis B   |
| <input type="checkbox"/> Tetanus booster (dT) or (TdaP) Date: _____      | <input type="checkbox"/> Hepatitis A   |
| <input type="checkbox"/> Mumps, measles, rubella (MMR)                   | <input type="checkbox"/> Varicella <input type="checkbox"/> Had chicken pox (chicken pox) Date: _____                |
| <input type="checkbox"/> Polio(IPV)                                      | <input type="checkbox"/> Meningococcal meningitis (MCV4)   |
| <input type="checkbox"/> Haemophilus influenzae type B (HIB)             | <input type="checkbox"/> Tuberculosis (TB) test <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____ |
| <input type="checkbox"/> Pneumococcal (PCV)                              |  |

**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 and will submit an Immunization Exemption Form to the Camp Shalom office before my child arrives at camp.**

Signature of Custodial Relationship Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Medication:**  This camper will not take any daily medications while attending camp.

This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. **Please send all medications in their 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:  Breakfast  Lunch  Dinner  Bedtime  Other time: \_\_\_\_\_

Amount or dose given: \_\_\_\_\_ How it is given: \_\_\_\_\_

Name of medication: \_\_\_\_\_ Date started: \_\_\_\_\_

Reason for taking it: \_\_\_\_\_

When it is given:  Breakfast  Lunch  Dinner  Bedtime  Other time: \_\_\_\_\_

Amount or dose given: \_\_\_\_\_ How it is given: \_\_\_\_\_

Name of medication: \_\_\_\_\_ Date started: \_\_\_\_\_

Reason for taking it: \_\_\_\_\_

When it is given:  Breakfast  Lunch  Dinner  Bedtime  Other time: \_\_\_\_\_

Amount or dose given: \_\_\_\_\_ How it is given: \_\_\_\_\_

Name of medication: \_\_\_\_\_ Date started: \_\_\_\_\_

Reason for taking it: \_\_\_\_\_

When it is given:  Breakfast  Lunch  Dinner  Bedtime  Other time: \_\_\_\_\_

Amount or dose given: \_\_\_\_\_ How it is given: \_\_\_\_\_

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)              | Diphenhydramine antihistamine/allergy medicine (Benadryl)     |
| Antihistamine/allergy medicine       | Lice shampoo or cream (Nix or Elimite)                        |
| Sore throat spray                    | Laxatives for constipation (Ex-Lax)                           |
| Calamine lotion                      | Dextromethorphan cough syrup (Robitussin DM)                  |
| Ibuprofen (Advil, Motrin)            | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |
| Guaifenesin cough syrup (Robitussin) | Antibiotic cream  |
| Generic cough drops                  | Aloe  |

Camper Name \_\_\_\_\_  
First Middle Last

Birth Date \_\_\_\_\_

**General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.** Has/does the camper:

- 1. Ever been hospitalized? .....  Yes  No
- 2. Ever had surgery? .....  Yes  No
- 3. Have recurrent/chronic illnesses? .....  Yes  No
- 4. Had a recent infectious disease? .....  Yes  No
- 5. Had a recent injury? .....  Yes  No
- 6. Had asthma/wheezing/shortness of breath? .....  Yes  No
- 7. Have diabetes? .....  Yes  No
- 8. Had seizures? .....  Yes  No
- 9. Had headaches? .....  Yes  No
- 10. Wear glasses, contacts, or protective eyewear? .....  Yes  No
- 11. Had fainting or dizziness? .....  Yes  No
- 12. Passed out/had chest pain during exercise? .....  Yes  No
- 13. Had mononucleosis ("mono") during the past 12 months? .....  Yes  No
- 14. If female, have problems with periods/menstruation? .....  Yes  No
- 15. Have problems with falling asleep/sleepwalking? .....  Yes  No
- 16. Ever had back/joint problems? .....  Yes  No
- 17. Have a history of bedwetting? .....  Yes  No
- 18. Have problems with diarrhea/constipation? .....  Yes  No
- 19. Have any skin problems? .....  Yes  No
- 20. Traveled outside the country in the past 9 months? .....  Yes  No

**Please explain "Yes" answers in the space below**, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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? .....  Yes  No  
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Health-Care Providers:**

Name of camper's primary doctor(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Name of dentist(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Name of orthodontist(s): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**What Have We Forgotten to Ask? Please provide in the space below** 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. **Attach additional information if needed.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Permission to Treat Authorization:**

I hereby give permission to the medical personnel to provide routine health care; to administer prescribed medications; and to administer emergency treatment for me/my child, including, but not limited to X-rays, routine tests and treatment and/or hospitalization; and to provide or arrange necessary related transportation for me/my child. I also agree to the release of any records necessary for treatment, referral, billing or insurance purposes. The camper's parent/guardian is the primary carrier of accident/health insurance.

If the person named herein is a minor, it is my intention that representatives of the camp be considered "personal representatives" for the purpose of disclosing health information that is protected under the Health Insurance Portability and Accountability Act of 1996. I also agree to the disclosure to camp representatives of protected health information of the person named herein in order to provide information related to the person's ability to participate in camp activities; and if the person named herein is a minor, to provide information to the camp representatives to keep me informed of my child's health situation.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the named person. This completed form may be photocopied for trips out of camp.

**Camper Agreement**

I understand and agree to abide by any restrictions placed on my activity at camp.  I Agree

Signature of Custodial Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_