



CAMP GROSVENOR - CAMPER HEALTH HISTORY - 2012

Camper Name: _____
Last First Middle

Male Female Birth Date _____ Age on July 1, 2012: _____ Weeks Attending _____

Camper Home Address: _____
Street Address City State Zip Code

Preferred Phone 1: _____ Preferred Phone 2: _____

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

Name: _____ Relationship to Camper: _____ Cell Phone: _____
Email: _____ Home Phone: _____ Work Phone: _____

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

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Cell Phone: _____
Email: _____ Home Phone: _____ Work Phone: _____

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

Name: _____ Relationship to Camper: _____ Preferred Phone: _____

Name: _____ Relationship to Camper: _____ Preferred Phone: _____

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 have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. (*Please describe below.*)

Medical Insurance Information:

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

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Phone Number (_____) _____

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: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver, which must be signed for attendance. (PAGE 1/2)

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: _____

Medication:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **Medications must be supplied in 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.**

- This camper will not take any daily medications while attending camp.
- This camper will take the following daily medication(s) while at camp: (please list & request Medication Administration Form)

- I give permission for the staff at Camp Grosvenor to dispense Tylenol to my child (name) _____ as needed for headaches, earaches, etc.
- I wish to be called before my child (name) _____ is given Tylenol.

Immunization History: Provide the month and year for each immunization. Starred (*)immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Diphtheria, tetanus, pertussis (DTaP) or (Tdap)* _____ Tetanus booster (dT) or (Tdap) * _____
 Mumps, Measles, Rubella (MMR)* _____ Polio (IPV)* _____
 Haemophilus influenzae type B (HIB) _____ Pneumococcal (PCV) _____
 Hepatitis A _____ Meningococcal meningitis (MCV4) _____
 Varicella vaccine _____ (chicken pox) Had chicken pox Yes No Tuberculosis (TB) test _____ Negative Positive

Hepatitis B: 1 _____ 2 _____ 3 _____ Hepatitis B Series must be in compliance prior to attendance at camp.

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: _____

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.**

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Camper: _____
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