Camper Health History Forms 2023

Applicant Information

Camper's Name:

____

First Middle Last

Camper's Gender: M / F Camper's Birth Date: _____/______/_________

How old will your child be during camp? _____ What grade will your child be entering this fall? _____

____

Parents/Guardians, please complete pages 1-5 of the Camper Health History Forms. Page 6 of the Camper Health History Forums MUST be completed and signed by your child's physician.

Parent/Guardian Full Name:______________________________ Relationship to Camper__________________

Home Address: ____

Street City State Zip Code

Primary Phone: ______________________ Primary mail:____

Second Parent/Guardian Full Name:___________________________ Relationship to Camper_______________

Home Address: ____

Street City State Zip Code

Primary Phone: ______________________ Primary mail:____

Emergency Contact Full Name:______________________________ Relationship to Camper_______________

Home Address:____

Street City State Zip Code

Primary Phone: ______________________ Primary mail:____

Allergies: ☐ No known allergies ☐ This camper is allergic to: ☐Food ☐ Medicine
☐ The environment (insect stings, hay fever, etc.)

☐ Other ***(Please describe below the camper's allergy and the reaction seen.)***

Diet, Nutrition:

☐ This camper eats a regular diet. ☐ This camper eats a vegetarian diet.

☐ This camper is lactose intolerant. ☐ This camper is gluten intolerant. ☐ Other ***(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 tis 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 Parent/Guardian: ________________________ **Date:**_______________ **Relationship to camper:**______________

Immunization History: Provide the month and year of each immunization. Copies of immunization forms from healthcare providers or local government are acceptable; please attach to this form.

Immunization		Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTap) or (TdaP)							
Tetanus booster (dT) or TdaP)							
Mumps, measles, rubella (MMR)							
Polio (IPV)							
Haemophilus influenzeae type B (HIB)							
Pneumococcal (PCV)							
Hepatitis B							
Hepatitis A							
Varicella (chicken pox)	☐ Had chicken pox Date:						
Tuberculosis (TB) Test		Date:	☐ Negative ☐ Positive				

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 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 at camp.

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. St. Tikhon's Summer Camp requires original pharmacy containers with labels that 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 medication	When it is given	Amount or dose given	How it is given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other________________		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other________		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other________		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other________		

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)

Ibuprofen (Advil, Motrin)

Phenylephrine decongestant (Sudafed PE)

Pseudoephedrine decongestant (Sudafed)

Antihistamine/allergy medicine

Guaifenesin cough syrup (Robitussin)

Sore throat spray

Diphenhydramine antihistamine/allergy medicine (Benadryl)

Generic cough drops

Dextromethorphan cough syrup (Robitussin DM)

Lice shampoo or cream (Nix or Elimite)

Antibiotic cream

Calamine lotion

Aloe

Laxatives for constipation (Ex-Lax)

Bismuth subsalicylate for diarrhea (Kaopectate, Pepto Bismol)

General Health: Circle "Yes" or "No" for each statement. Explain "Yes" answers 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 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 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 last 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 country visited and dates of travel.

Mental, Emotional, and Social Health: Circle "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 question. 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.*

Physician's Health Assessment 2023

This page to be completed by the camper's primary care physician.

Camper's Name: ____
First Middle Last

Camper's Birth Sex: M / F Camper's Birth Date: _____/______/_________

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

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Phenylephrine decongestant (Sudafed PE)
- Pseudoephedrine decongestant (Sudafed)
- Chlorpheniramine maleate
- Diphenhydramine (Benadryl)
- Laxatives for constipation (Ex-Lax)
- Bismuth subsalicylate (Pepto-Bismol)
- Lice shampoo or scabies cream (Nix or Elimite)
- Guaifenesin
- Dextromethorphan
- Calamine lotion
- Generic cough drops
- Aloe
- Topical antibiotic cream
- Chloraseptic (sore throat spray)

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM and remaining sections of this form. Attach additional information if needed.

Physical exam done today? Yes / No (If "no," date of last physical:_________________(must be within last 12 months)
Month/day/year

Weight:________ lbs Height:___ft_____in
Blood Pressure_____/_______

- ☐ **Allergies:** ☐ **No Known Allergies**
- ☐ **To foods (list):**
- ☐ **To medications (list):**
- ☐ **Environmental (list):**
- ☐ **Other allergies (list):**
- ☐ **Describe previous reactions:**

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions. ***(Describe below.)***

The camper is undergoing treatment(s) at this time for the following conditions(s): *(Describe below.)* ☐ None.

Medication: ☐ No daily medication. ☐ Will take the following prescribed medication(s) while at camp:
(Name, dosage, frequency – describe below.)

Other treatments/therapies to be continued at camp: *(Describe below.)* ☐ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ Yes ☐ No

If you answered "yes" to the above, what do you recommend? ***(Describe below – attach additional information if needed.)***

I have reviewed the CAMPER HEALTH HISTORY FORM and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Name of licensed provider (please print):_______________________________ Signature:_____________________________

Title:_______________________________

Office address:____

Telephone(_______)_________________ Date__________________

By May 15, please mail this form to St Tikhon's Summer Camp DOEPA, PO Box 123, Waymart, PA 18472