EMMA KAUFMANN CAMP HEALTH HISTORY FORM #1

Please return to the office by May 25, 2012.

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

Camper Name: _____ Grade (Fall 2012): _____
First M iddle Last

Session Attending: (**Please Circle all sessions)** Sabra Aleph Session 1 Session 2 Gesher Specialty First Experience

Male Female Social Security #: _____ Birth Date: _____ Age on arrival at camp: _____
Month/Day/Year

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

1) ***Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.***
2) ***Send the original, signed FORM 1 to camp by the requested date.***
3) ***Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.***
4) ***After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.***

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: _____

Email: _____ _____

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insects stings, hay fever, etc.)
☐ Other ***(Please describe below what the camper is allergic to and the reaction seen.)***

Diet, Nutrition: ☐ The camper eats a regular diet. ☐ This camper eats a regular **vegetarian** diet. ☐ The 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 camp 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 Number: _____

Subscriber's Social Security Number: _____ Subscriber's Birthdate: _____

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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.

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 influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) Had Chicken Pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test Date: _____ ☐ Negative ☐ Positive

If you 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 medication 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. ***Please review camp instructions about required packaging/containers. Original pharmacy containers with label need to be provided 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. There is a list of over the counter medications that are given at the discretion of the nurses according to certain established guidelines. This can be found in the Parent Manual on page 7. If there are any concerns please contact our Health Center Director, Joan Addicks, RN at 304-599-6206.***

Name of Medication	Date Started	Reason for taking it	When it is given	Amount of dose given	How it is given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime Other time: _____		

Health-Care Providers:

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

Name of dentist(s): _____ Phone: _____

Name of orthodontist(s): _____ Phone: _____

EMMA KAUFMANN CAMP HEALTH HISTORY FORM #1

General Health History: ***Check "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 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 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 "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name and 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? (History of abuse, death of loved one, family change, adoptions, foster care, new sibling, survived a disaster, others)	☐ Yes	☐ No

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

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.***

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.

Parents/Guardians: STOP here. The rest of the form is completed when the camper arrives at camp. Keep a copy for your records.

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Individual Health Record (For Camp Use Only)

Initial **Screening** **Date/Time:** _____ **Initials:** _____

☐ **Screening** has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival?	☐ No	☐ Yes as noted below
B. History of exposure to communicable disease?	☐ No	☐ Yes as noted below
C. Additions or corrections to information on this health history?	☐ No	☐ Yes as noted below
D. Medication given to health-care staff?	☐ No	☐ Yes as noted below
E. Any signs/symptoms of head lice?	☐ No	☐ Yes as noted below

Provider notes: (date/time/initial all entries) _____

Exit Note: Check one of the following:

☐ Left camp this day with no reported illness or injury symptoms.

☐ Left camp this day with the following problem/concern:

_____

_____

This person was told about the problem and instructed about follow-up as noted above: _____

Date/Time: _____ Initials: _____

CAMPER NAME: _____ SESSION(s) _____ GRADE (Fall 2012) _____

EMMA KAUFMANN CAMP
PHYSICIAN EXAMINATION FORM #2

Medical Personnel: Please review the Camper Health History Form (Form #1) and complete all remaining sections of this Form (Form #2). Attach additional information if needed.

Physical Examination done today: ☐ Yes ☐ No (If "No," date of last physical: _____)
ACA accreditation standards specify physical exam within last 24 months. Month/Day/Year

Medical Examination:

Code: N= Normal A= Abnormal (please explain) O= Not evaluated

BP _____ Weight _____
Height _____ Lungs _____
Skin _____ Heart _____
Eyes _____ Abdomen _____
Ears _____ GU _____
Nose _____ Extremities _____
Throat _____ Spine _____
Teeth (Braces) _____
General Appraisal _____

(*For Girls and Women)* Has this person menstruated? _____
If not, has she been told about it? _____
If so, is her menstrual history normal? _____

Recommendations and Restrictions While at Camp:

Special Diet / Eating Disorder _____
Swimming, Diving _____
Limitations to Activity _____

Allergies:

Medication Allergies _____ Food _____
Bee Stings/Insect Bites _____ Other _____
Poison Ivy _____

Health History: Y= Yes N= No (please explain)

Seizure Disorder _____ Bed Wetting _____ Mononucleosis _____ Communicable Disease (specify) _____
Diabetes _____ Athletic Injuries _____ Bleeding/Clotting _____ Heart Abnormality _____
Chicken Pox _____ Musculoskeletal _____ Rheumatic Fever _____ Asthma _____
Chronic Illness _____ Recurring Infection _____
Has camper been diagnosed with ADD or ADHD? _____ If yes, is the camper currently on medications? _____
Will camper remain on medication during summer? _____ If no, explain _____

List All Medications: (Prescribed & over-the-counter) and list conditions for which they are prescribed.

NAME	DOSAGE AMOUNT	FREQUENCY	DURATION	ROUTE	MD SIGNATURE

I have examined the person described above and have reviewed his/her health history. This person is physically able to engage in camp activities except as noted above.

_____ , MD _____
Signature of Examining Physician Date

_____ _____ _____
Print Name Office Address Office Phone