

**CAMPER HEALTH FORM****THIS IS A MANDATORY HEALTH FORM!**

Please return this form to:

891 Queen street, Southington, ct. 06489

Camper Name: \_\_\_\_\_

Session Attending:  1<sup>st</sup>  2<sup>nd</sup> Weeks

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security No: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_

Second Parent/Guardian or Emergency Contact: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_

**Authorization for Healthcare:**

*This health history is correct, and the camper described has permission to participate in all camp activities except as noted by me and/or the examining physician. I give permission to the physician selected by camp faithful to order x-rays, routine tests, and treatment for the health of the camper. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection(s), anesthesia, and/or surgery for the camper. I give my permission to camp faithful medical staff to provide routine health care, dispense medication and seek emergency treatment. This form may be photocopied.*

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

**Medical Contact:**

Name of camper's physician: \_\_\_\_\_ Office Phone: ( ) \_\_\_\_\_

Name of camper's dentist/orthodontist: \_\_\_\_\_ Office Phone: ( ) \_\_\_\_\_

**Billing Information:** There is generally no charge for health care received from our Camp Health Center.

However, parents/guardians are responsible for health care given by an out-of-camp provider.

To whom should we route charges for your child's health care?

**PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD (FRONT & BACK)**

Card holders name: \_\_\_\_\_ social security # \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Address: \_\_\_\_\_

Phone No: ( ) \_\_\_\_\_

**Immunization History:** Please provide the month & year of immunizations. Starred (\*) immunizations must be current.**Immunization Dose 1 Dose 2 Dose 3 Dose 4**

DTP: Diphtheria, Tetanus, Pertussis \* \* \* \*

Td: Tetanus Booster (Must be current within past 10 yrs) \*

MMR: Mumps, Measles, Rubella \* (Measles Booster) \*

IVP/OPV: Polio \* \* \* \*

Hep B: Hepatitis B

Hib: H, Influenzae, Type B

**Muscular-skeletal Information:** Please initial the statement which applies to your camper.

\_\_\_\_\_ Camper has no back, knee, ankle, or joint problems.

\_\_\_\_\_ Camper has this back, knee, ankle, and/or joint problem: \_\_\_\_\_

We manage this problem by doing: \_\_\_\_\_

Describe the things you do to avoid aggravating the problem: \_\_\_\_\_

**Allergies:** Please initial the statement(s) which apply to your camper. Camper has no known allergies.Camper has an allergy to this food: \_\_\_\_\_ Does this cause anaphylaxis?  Yes  No

Describe the reaction and what is done to manage it: \_\_\_\_\_

Camper has an allergy to this medication: \_\_\_\_\_ Does this cause anaphylaxis?  Yes  No

Describe the reaction and what is done to manage it: \_\_\_\_\_

\_\_\_\_\_ Camper has this environmental allergy: \_\_\_\_\_

Describe the reaction and what is done to manage it: \_\_\_\_\_

(Please attach additional information if necessary)

**Chronic Concerns:** *Please initial the statement which applies to your camper.*

\_\_\_\_\_ Camper has no chronic health concerns and is capable of full participation in the program.

\_\_\_\_\_ Camper has the following chronic health concern(s):

- Asthma  Diabetes  Heart
- Back pain/injury  Digestive or bowel disorder  Knee or ankle
- Breathing difficulty  Headaches/migraines  Sleep problem

*Please provide information about supportive healthcare needed for each checked item (attach additional information if necessary).*

**Medication**

\_\_\_\_\_ Camper does not take medication on a routine basis.

\_\_\_\_\_ Camper takes routine medication as follows. Make sure to indicate only as needed. *(Please attach additional information if necessary)*

**Please inform your physician that all of our medications are administered on a mealtime and bedtime schedule.**

**General History:** *Please provide additional information when necessary.*

- Yes  No Camper has had chicken pox/vaccine \_\_\_\_\_
- Yes  No Camper has had mononucleosis in the past 12 months \_\_\_\_\_
- Yes  No Camper's hearing is within normal ranges \_\_\_\_\_
- Yes  No Camper's vision, including corrected vision, is within normal ranges (20/20) \_\_\_\_\_
- Yes  No Camper makes noises while sleeping (snoring, talking in sleep, etc.) \_\_\_\_\_
- Yes  No Camper wets the bed at night \_\_\_\_\_
- Yes  No Camper has toileting issues \_\_\_\_\_
- Yes  No Camper sleepwalks or has night terrors \_\_\_\_\_
- Yes  No Camper is free of illness or need of surgery that would effect program participation \_\_\_\_\_

Name of medication: \_\_\_\_\_ Reason for taking: \_\_\_\_\_

Dose taken: \_\_\_\_\_ How often each day? \_\_\_\_\_ *Please circle:* am noon pm bedtime

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Dose taken: \_\_\_\_\_ How often each day? \_\_\_\_\_ *Please circle:* am noon pm bedtime

**Diet:** *Please initial the statement(s) which apply to your camper. Our expectation is that campers eat the provided menu. We can work effectively with some medically prescribed diets, but cannot cater to individual food likes and dislikes.*

\_\_\_\_\_ Camper eats a regular, varied diet. Any issues? \_\_\_\_\_

\_\_\_\_\_ Camper is a vegetarian.

\_\_\_\_\_ Camper is lactose intolerant. *If so, please check one:*

- Camper uses a product like Lactaid and/or self-manages the intolerance.
- Camper needs a lactose-free diet that includes no lactose in baked items (i.e: breads, cookies, cakes, etc.).

\_\_\_\_\_ Camper responds with an anaphylactic reaction when he eats this food:

**Mental & Emotional Health Information:** *If you mark 'Yes' to any item in this section, please attach a statement which:*

1) *Describes the concern and your management plan for addressing it; AND*

2) *Describes the support necessary from North Star Camp to support your plan.*

- Yes  No Camper has a diagnosis of ADD (Attention Deficit Disorder) or ADHD.
- Yes  No Camper has a psychiatric diagnosis such as Depression, OCD, Panic or Anxiety Disorder.
- Yes  No Camper has a learning disability.
- Yes  No Camper has an emotional health concern.
- Yes  No In the past year, camper has seen (or is currently seeing) a professional regarding mental health and/or emotional concerns.

**Emergency Contact:** *Who do you want us to contact in an emergency if the parent/guardian cannot be reached?*

First Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

**What have we forgotten to ask?**

*Please provide additional information about your camper's health which may have been neglected on this form:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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