# CAMPER HEALTH FORM

***THIS IS A MANDATORY HEALTH FORM!***
*Please return this form to:*
*891 Queen street, Southington, ct. 06489*

Camper Name: ________________________________________ Session Attending: 1st 2nd 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: Diptheria, 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**

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

__________ 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)*

Name of medication: ______________________________ Reason for taking: ______________________
Dose taken: __________________ How often each day? ____________ *Please circle:* am noon pm bedtime

Name of medication: ______________________________ Reason for taking: ______________________
Dose taken: __________________ How often each day? ____________ *Please circle:* am noon pm bedtime

**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 ______________________

**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 Camp Faithful 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:*

# Camp Nursing Notes *(For Health Center use only)*

**Date____________Initial____________**

SCREENING has been conducted as per camp faithful protocol and significant findings noted.

Yes No Any signs/symptoms of illness or injury upon arrival? _______________________________________

Yes No Any history of exposure to communicable disease? _________________________________________

Yes No Any additions or corrections to information on health history? _______________________________

Yes No Medication given to nurse? ____________________________________________________________

Yes No Any signs/symptoms of head lice? ______________________________________________________

## EXIT NOTES:

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

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

Nursing instructions provided about concern: ________________________________________________________________________

**Camp Health Care Provider's Signature: _____________________________________________ Date: ____________________**