

# Camper Health History Form

To be completed and signed by parent/guardian. Please print or type all entries. Completed form MUST accompany registration form.



## GENERAL INFORMATION

CAMPER'S NAME: \_\_\_\_\_ Name Preferred: \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Grade completed by June: \_\_\_\_\_ Height \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Parent/Guardian Work Phone: Mother: (\_\_\_\_) \_\_\_\_\_ Father: (\_\_\_\_) \_\_\_\_\_

Parent/Guardian Cell Phone: Mother: (\_\_\_\_) \_\_\_\_\_ Father: (\_\_\_\_) \_\_\_\_\_

## IN CASE OF EMERGENCY, PLEASE NOTIFY (indicate by number the order desired: 1, 2, 3)

( ) Parent/ Guardian named above

( ) \_\_\_\_\_ Relationship to camper \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

( ) \_\_\_\_\_ Relationship to camper \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ PHONE: \_\_\_\_\_

DENTIST/ORTHODONTIST NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

## INSURANCE INFORMATION:

Are you covered by medical/hospitalization insurance? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, indicate your carrier or plan name and complete below:[i.e. Blue Cross] \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

POLICY HOLDER'S NAME: \_\_\_\_\_

(This information is required since each camper is covered by limited accident and medical insurance – in excess of parents' own insurance – NOTE: The Heights policy is a secondary policy. PA state law prohibits duplicate payments.)

## ILLNESSES AND INJURIES (Check those that apply)

____ Asthma	____ Bleeding/Clotting Disorder	____ Chicken Pox	____ Convulsions/Seizures
____ Diabetes	____ Frequent Ear Infections	____ Hypertension	____ Upper Respiratory Infections
____ Tuberculosis	____ Heart Disease/Defect	____ Kidney Disease	____ Frequent Sore Throats
____ Other (Specify) _____			

DATE OF CAMPER'S LAST HEALTH EXAM \_\_\_\_\_ Were any problems noted at that time? \_\_\_\_\_

Is camper currently under a physician's care for a medical problem? Y N Explain: \_\_\_\_\_

Since camper's last health exam, has he/she had:

- A serious injury requiring medical attention? Date: \_\_\_\_\_ What? \_\_\_\_\_
- A surgical operation or fracture? Date: \_\_\_\_\_ What? \_\_\_\_\_
- A diagnosed infectious/communicable disease? Date: \_\_\_\_\_ Disease: \_\_\_\_\_
- Medication prescribed by a physician to be taken on a regular basis? Date: \_\_\_\_\_ What? \_\_\_\_\_
- A physician's restriction from participating in any school physical activity? \_\_\_\_\_

**NOTE: A written statement from the camper's physician may be needed in order for your child to participate in strenuous camp activities such as swimming, hiking, or sports if you checked any of the above questions.**

**ALLERGIES (Check those that apply)**

- Animals       Foods       Insect Stings       Seasonal/Environmental
- Medications       Plants (Poison Ivy, etc)       Other (Specify) \_\_\_\_\_

Please explain any allergies checked above and list treatment if any is necessary: \_\_\_\_\_

**IMMUNIZATIONS**

Are all immunizations up to date? Yes No Date of late Tetanus (DPT, DT, TT) Shot **MUST** be listed here: \_\_\_\_\_

**OTHER HEALTH CONDITIONS (Check those that apply)**

- Athlete's Foot       Ear Tubes (How protected)       Fainting       Hearing Impairment
- Previous Homesickness       Wears Glasses/Contacts       Nosebleeds       Special Dietary Regimen

Please explain any of above checked items or other conditions not mentioned: \_\_\_\_\_

**CAMPER MEDICATIONS**

**ALL camper medications will be checked by the Camp Nurse upon arrival.** The Camp Nurse will insure that medications are administered in accordance with physician's instructions. For these purposes, **Medication** is broadly defined to include prescription and non-prescription medications, home remedies, vitamins, inhalers, drops, and medicated creams. Limited types of common over-the-counter medications are available at each camp. We ask your full cooperation in this matter so that every camper's health and well being can be properly safeguarded. **Please complete one 'Authorization For Medication Administration Form' for each medication. You may copy the form. NO MEDICATION WILL BE GIVEN WITHOUT THIS COMPLETED MEDICATION FORM! \*\*IMPORTANT – THIS SECTION MUST BE COMPLETED FOR ATTENDANCE AT THE CAMP\*\***

**CERTIFICATION AND AUTHORIZATION**

I certify that the information provided on both sides of this Health History Form is, to the best of my knowledge, complete and accurate. I know of no reason(s), other than the information indicated on this form why my son/daughter should not participate in all camp activities. I take full responsibility for any medical problems (illness or injury) that occur as a result of my failure to disclose medical condition, restrictions, or limitations of my child. I understand the Commonwealth of Pennsylvania requirement that all campers be examined by the Health Care Supervisor on the day of registration and give my permission for the conduct of such an examination. My son/daughter \_\_\_\_\_, has permission to participate in the activities associated with the summer camping program of the The Heights – Retreat and Arts Center. **Further, in the event of an illness or emergency, the Camping Coordinator or designee is authorized to act in my behalf in securing medical treatment for my child named above.**

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

**FOR CAMP USE ONLY: ON-SITE HEALTH EXAMINATION**

General Health Condition: \_\_\_\_\_  
Illness experienced or exposed to during preceding 30 days: \_\_\_\_\_  
Recommendations and restrictions (activity, diet, etc.) \_\_\_\_\_

# Authorization for Medication Administration

PLEASE NOTE: If your child requires more than one medication, you must complete and sign a form for each of the medications. THIS APPLIES TO ALL PRESCRIPTION AND NONPRESCRIPTION MEDICATIONS, OINTMENTS, AND DROPS, etc. **You may copy this form.** If your child must receive medication during his/her scheduled summer camping session, please complete this form and mail it with the Registration Form. The prescribed and described medication must be brought to camp with your child and given to the Camp Nurse at the time of registration. **NO medication will be given from a container unless his/her name is on the original container. This form must be signed by your physician.**



## PRESCRIBING PHYSICIAN INFORMATION

1. Child's Full Name: \_\_\_\_\_
2. Diagnosis: \_\_\_\_\_
3. Medication Prescribed and Term: \_\_\_\_\_
4. Prescribed Dosage: \_\_\_\_\_
5. Time Schedule: \_\_\_\_\_
6. Possible Side Effects: \_\_\_\_\_

I certify that it is imperative that the medication prescribed above be taken during this child's camping:

\_\_\_\_\_  
(Physician's Signature) (Printed Name) (Phone) (Date)

## PARENT AUTHORIZATION

I, \_\_\_\_\_ give my consent to the Camp Nurse to administer the above  
(Name of Parent/Guardian)  
medication to my child during \_\_\_\_\_ his/her summer camp session from  
(Name of Child)

July 22 July 26  
(Starting Date) (Closing Date)

\_\_\_\_\_  
(Parent/Guardian Signature) (Printed Name) (Phone) (Date)

### THIS SECTION TO BE COMPLETED BY ONLY THE CAMP NURSE

1. \_\_\_\_\_ Permission form completed
2. \_\_\_\_\_ Safety type container
3. \_\_\_\_\_ Original prescription label
4. \_\_\_\_\_ Name of this child is on the label
5. \_\_\_\_\_ Date on prescription label is current/expiration date is not passed
6. \_\_\_\_\_ Dosage, name of drug, frequency of administration on label is consistent with this form
7. \_\_\_\_\_ OTC, original container, expiration date is not passed
8. \_\_\_\_\_ Will carry on person \_\_\_\_\_
9. \_\_\_\_\_ Other instructions: \_\_\_\_\_

\_\_\_\_\_  
(Camp Nurse Approval) (Date)