Casowasco Camp & Retreat Center

CAMPER HEALTH HISTORY: FORM 1

Adapted from form developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Mail this form to the address below 3 weeks prior to the start of camp.

Casowasco Camp & Retreat Center
158 Casowasco Drive
Moravia, NY 13118

Dates will attend camp: from _____ to _____
month/day/year *month/day/year*

Camper Name: _____
First *Middle* *Last*

Gender: _____ 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 (pgs. 1-4) 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: _____ Relation to Camper: _____ Preferred Phone: (_____) _____ - _____

Secondary Phone: (_____) _____ - _____ Email: _____

Home Address: _____
(Iif different from above) *Street Address* *City* *State* *Zip Code*

Second parent/guardian or other emergency contact:

Name: _____ Relation to Camper: _____ Preferred Phone: (_____) _____ - _____

Secondary Phone: (_____) _____ - _____ Email: _____

Additional emergency contact in event parent(s)/guardian(s) listed above can not be reached:

Name: _____ Relation to Camper: _____ Preferred Phone: (_____) _____ - _____

Allergies: ☐ No Known Allergies ☐ This Camper is allergic to: ☐ Food ☐ Medicine ☐ The Environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet/Nutrition: ☐ This camper eats a regular diet. ☐ This Camper eats a regular vegetarian diet. ☐ This camper eats a regular vegan diet.
☐ This camper is lactose intolerant. ☐ This camper is gluten intolerant. ☐ Other, ***please explain in space.***

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: Is 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 all information is readable.

Insurance Company: _____ Policy #: _____

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 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: _____ Relation to Camper: _____

If for religious or other reasons you cannot sign this form, contact the camp office for a legal waiver that must be signed for attendance.

(for camp use) Camper Name: _____ *Last* _____ *First* _____ *Middle* _____ (for Camp Use) Program: _____ _____ _____ _____ (for camp use) Rcv: _____

CAMPER HEALTH HISTORY **FORM 1** (pg. 2)

Adapted from form developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses.*

Camper Name: _____
First *Middle* *Last*

Birth Date: _____
month/day/year

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must include date to meet ACA Standard. 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 *							
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 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 Custodial Parent/Guardian: _____ Date: _____ Relation to Camper: _____

Medication:
□ This camper will not take any daily medications while attending camp
□ This campe will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their helath. This includes vitamins & natural remedies. **Medications must be in their original containers, with appropriate labels which show the camper's name and how the medication should be given. Please provide enough of each medication to last the entire time the camper will be at camp.**

Name of medication	Date started	Reason for taking	When it is Given	Amount or dose given	How it is given
			□ Breakfast □ Lunch □ Dinner □ Hour of Sleep (Bed) □ Other Time:		
			□ Breakfast □ Lunch □ Dinner □ Hour of Sleep (Bed) □ Other Time:		
			□ Breakfast □ Lunch □ Dinner □ Hour of Sleep (Bed) □ Other Time:		
			□ Breakfast □ Lunch □ Dinner □ Hour of Sleep (Bed) □ Other Time:		

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. **Please cross out those that campers should NOT be given.**

Acetaminophen (discomfort/fever, headache, pain relief)
Ibuprofen (discomfort/fever, menstrual cramps, headache, muscle aches)
Hydrogen Peroxide/Antiseptic Solution (topical, wound cleaning)
Bacitracin/Neomycin/Polymyxin (topical, antibiotic ointment)
Calamine/Caladryl Lotion (topical, skin irritation)
Hydrocortisone Cream (topical, skin irritation)
Cepecol Losenges (throat irritation, cough)
Chloraseptic (thoat irritation)
Robitussin (cough suppressant, cough expectorant)
Visine (eye irritation)
Benadryl (topical for skin irritation, oral for allergies, cold symptoms)
Claritin (allergy symptoms)
Sudafed (allergy, sinus, cold symptoms)
Imodium (diarrhea, cramps, bloating)
Mylanta (hearburn, indigestion, upset stomach)
Tums (heartburn, indigestion, upset stomach)
Pepto-Bismal (nausua, heartburn, indige--stion, upset stomach, diarrhea)
Milk of Magnesia (constipation)
Sunscreen (sun exposure prevention)

CAMPER HEALTH HISTORY **FORM 1** (pg. 3)

Adapted from form developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses.*

Camper Name: _____
First *Middle* *Last*

Birth Date: _____
month/day/year

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/Does the camper:

1.	Ever been hospitalized?	□ Yes	□ No	13.	Had fainting or dizziness?	□ Yes	□ No
2.	Ever had surgery?	□ Yes	□ No	14.	Passed out/had chest pain during exercise?	□ Yes	□ No
3.	Have recurrent/chronic illnesses?	□ Yes	□ No	15.	Had mononucleosis ("mono") during the past 12 months?	□ Yes	□ No
4.	Had a recent infectious disease?	□ Yes	□ No	16.	If female, have problems with periods/menstruation?	□ Yes	□ No
5.	Had a recent injury?	□ Yes	□ No	17.	Have problems falling asleep/sleepwalking?	□ Yes	□ No
6.	Had asthma/wheezing/shortness of breath?	□ Yes	□ No	18.	Ever had back or joint problems?	□ Yes	□ No
7.	Have diabetes?	□ Yes	□ No	19.	Have a history of bedwetting?	□ Yes	□ No
8.	Had seizures?	□ Yes	□ No	20.	Have problems with diarrhea/constipation?	□ Yes	□ No
9.	Had headaches?	□ Yes	□ No	21.	Have any skin problems?	□ Yes	□ No
10.	Wear glasses, contacts, or protective eyeware?	□ Yes	□ No	22.	Traveled outside the country in the past 9 months?	□ Yes	□ No
11.	Had a significant head injury?	□ Yes	□ No	23.	Had high blood pressure?	□ Yes	□ No
12.	Had frequent ear infections?	□ Yes	□ No	24.	Been diagnosed with a heart related issues/heart murmrur?	□ Yes	□ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

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 last 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 any "Yes" answers in the space below, noting the number of the questions and ***indicate management advice.*** The camp may contact you for additional information.

Health-Care Providers:

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

Name of camper's dentist(s): _____ Phone: (_____) _____ - _____

Name of camper's 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 campe program. ***Attach additional information if needed.***

Parents/Guardians: STOP here. Page 4 of this form is completed when/while the camper arrives/is at camp.

Keep a copy of pages 1-3 for your records, and then send all 4 pages to camp 3 weeks prior to the start of your camper's sessions

CAMPER HEALTH HISTORY **FORM 1** (pg. 4)

Adapted from form developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses.*

Camper Name: _____
First *Middle* *Last*

Birth Date: _____
month/day/year

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 diseases?..... □ 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, if yes, properly bagged and labeled?..... □ No □ Yes, as noted below
E. All consent signatures present?..... □ No □ Yes, as noted below
F. Any signs/symptoms or recent exposure to head lice or bed bugs?..... □ No □ Yes, as noted below

Provider Notes/Individual Health & Treatment Log: (date/time/initial all entries; use additional paper as needed.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Exit from Camp: Check one of the following:

□ Camper left at the end of the session with no reported illness or injury symptoms.

□ Camper left at the end of the session with the following health-related problem/concern: _____

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

_____ _____ _____ _____
Name of Person Informed *Date Informed* *Initials of Informer* *Initials of Informee*

□ Camper left early from the session with no reported illness or injury symptoms.

Date Left: _____ Reason: _____

□ Camper left early from the session due to the following health-related problem/concern:

Date Left: _____ Reason: _____

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

_____ _____ _____ _____
Name of Person Informed *Date Informed* *Initials of Informer* *Initials of Informee*

Casowasco Camp & Retreat Center

Recommendations for Licensed Medical Personnel

FORM 2

Adapted from form developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Mail this form to the address below 3 weeks prior to the start of camp.

Casowasco Camp & Retreat Center
158 Casowasco Drive
Moravia, NY 13118

To Parent(s)/Guardian(s): Complete this section ONLY and give this form (FORM 2) and a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review.

Dates will attend camp: from _____ (month/day/year) to _____ (month/day/year)

Camper Name: _____ (First / Middle / Last)

Gender: _____ Birth Date: _____ (month/day/year) Age on arrival at camp: _____

Camper home address: _____ (Street Address)

_____ (City / State / Zip Code)

Custodial parent(s)/guardian(s) phone: (_____) _____ - _____

Parent(s)/guardian(s) STOP here. Rest of form to be completed by medical personnel.

The following non-prescription medicines are stocked in the camp Health Center 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	Visine
Ibuprofen	Benadryl
Hydrogen Peroxide/Antiseptic Solution	Claritin
Bacitracin/Neomycin/Polymyxin	Sudafed
Calamine/Caladryl Lotion	Imodium
Hydrocortisone Cream	Mylanta
Ivarest Cream	Tums
Cepecol Lozenges	Pepto-Bismal
Chloraseptic	Milk of Magnesia
Robitussin	Sunscreen

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form RECOMMENDATIONS FOR LICENSED MEDICAL PERSONNEL (FORM 2). *Attach additional information if needed.*

Physical exam done today: □ Yes □ No (if "No", date of last physical: _____ (month/day/year))

ACA Standards specify physical exam should be within the last 12 months of the last day of camp

Weight: _____ lbs. Height: _____ ft. _____ in. Blood Pressure: _____/_____

Allergies: □ No Known Allergies

□ To foods (list): _____

□ To medications (list): _____

□ To the environment (list): _____

□ Other allergies (list): _____

Describe previous reactions:

Diet/Nutrition: □ Eats a regular diet. □ Has a medically prescribed meal plan or dietary restrictions ***(describe below):***

This camper is undergoing treatment at this time for the following conditions: ***(describe below)*** □ NONE

Medication: □ No Daily Medication □ Will take the following prescribed medication(s) while at camp **(must list name, dose, time, frequency 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? □ NO □ YES

If you answered "YES" to the question above, what do you recommend? (Describe below; attach additional information if needed)

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), 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). All information included on the CAMPER HEALTH HISTORY FORM (FORM 1) and the RCOMMENDATIONS FOR LICENSED MEDICAL PERSONNEL (FORM 2) is accurate and has my professional endorsement."

Name of Licensed Provider (please print): _____ Signature: _____ Title: _____

Office Address: _____ (Street Address / City / State / Zip Code)

Telephone: (_____) _____ - _____ Date: _____

(for camp use) Camper Name: _____ (Last / First / Middle) (for Camp Use) Program: _____ (for camp use) Rcv: _____