



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: _____
(if 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)

Camper Name: _____
First Middle Last

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

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
Diphtheria, 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)	<input type="checkbox"/> Had Chicken Pox Date: _____					
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative <input type="checkbox"/> 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 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. 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
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Hour of Sleep (Bed) <input type="checkbox"/> Other Time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Hour of Sleep (Bed) <input type="checkbox"/> Other Time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Hour of Sleep (Bed) <input type="checkbox"/> Other Time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Hour of Sleep (Bed) <input type="checkbox"/> 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) | Chloraseptic (throat irritation) | Imodium (diarrhea, cramps, bloating) |
| Ibuprofen (discomfort/fever, menstrual cramps, headache, muscle aches) | Robitussin (cough suppressant, cough expectorant) | Mylanta (heartburn, indigestion, upset stomach) |
| Hydrogen Peroxide/Antiseptic Solution (topical, wound cleaning) | Visine (eye irritation) | Tums (heartburn, indigestion, upset stomach) |
| Bacitracin/Neomycin/Polymyxin (topical, antibiotic ointment) | Benadryl (topical for skin irritation, oral for allergies, cold symptoms) | Pepto-Bismal (nausea, heartburn, indigestion, upset stomach, diarrhea) |
| Calamine/Caladryl Lotion (topical, skin irritation) | Claritin (allergy symptoms) | Milk of Magnesia (constipation) |
| Hydrocortisone Cream (topical, skin irritation) | Sudafed (allergy, sinus, cold symptoms) | Sunscreen (sun exposure prevention) |
| Cepecol Lozenges (throat irritation, cough) | | |

CAMPER HEALTH HISTORY FORM 1 (pg. 3)

Camper Name: _____
First Middle Last

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

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

- Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?..... Yes No
- Ever been treated for emotional or behavioral difficulties or an eating disorder?..... Yes No
- During the last 12 months, seen a professional to address mental/emotional health concerns?..... Yes No
- Had a significant life event that continues to affect the camper's life?..... Yes No
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

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:

_____ <i>Name of Person Informed</i>	_____ <i>Date Informed</i>	_____ <i>Initials of Informer</i>	_____ <i>Initials of Informee</i>
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- 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:

_____ <i>Name of Person Informed</i>	_____ <i>Date Informed</i>	_____ <i>Initials of Informer</i>	_____ <i>Initials of Informee</i>
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