

SUMMER CAMP HEALTH INFORMATION SECTION

Please forward to SHS within two months or less from start of camp.

**PLEASE ALSO ATTACH HEALTH EXAMINATION FORM PROVIDED BY CHILD'S PHYSICIAN
AND DATED WITHIN TWO YEARS OR LESS FROM CAMP INCEPTION**

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

If your child will be participating in a full day of camp, if you wish the child to participate in the swimming pool sessions, please indicate swimming ability/experience below.

Inexperienced/Beginner Moderately Experienced/Novice Experienced/Advanced

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General Questions (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	23. Has problems with diarrhea/ constipation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleep- walking?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			
16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions. Use back of form if necessary

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test

Date of last test _____

Result: Positive Negative

Please give all dates of immunization* for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____
-or Measles		_____	_____	_____	_____	_____
-or Mumps		_____	_____	_____	_____	_____
-or Rubella		_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____

*Note, if any vaccines do not apply please write N/A

Health Waiver/Permission to Treat

Name: _____

As the legal parent and/or guardian of _____, I grant permission to provide routine health care, administer prescribe medications, and seek emergency medical treatment to my child in case of emergency.

In the case of doctor prescribed medication, I will provide a written letter with instructions to the Office Manager.

Signed: _____

Print Name: _____

Emergency Information

Contact #1: _____

Phone #1: _____

Phone#2: _____

Contact #2: _____

Phone #1: _____

Phone #2: _____

Contact #3: _____

Phone #1: _____

Phone #2: _____

Special Needs Notification: *Must be forwarded 2 months or less before camp starts.*

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In order to be informed of medical, physical, or other needs/restrictions for your camper(s), parents are requested to complete the following form for each registered camper.

Camper's name and age: _____ Age: _____

- Medical Allergies: No Yes. Describe: _____
- Food Allergies: No Yes. Describe: _____
- Activity Restrictions: No Yes. Describe: _____
- Physical Restrictions: No Yes. Describe: _____
- Diabetes: No Yes. Describe: _____
- History of Seizures: No Yes. Describe: _____
- Recent Surgeries: No Yes. Describe: _____
- Other Conditions: No Yes. Describe: _____

Use back of form to elaborate, if needed.

SPECIAL INSTRUCTIONS RELATED TO ALLERGIES TO BEE STINGS, ETC...

What is the child specifically allergic to:

Are you sending her/him to camp with special medications/epi-pen/etc... No Yes.
Describe: _____

If yes, what do you want us to do in case of a related emergency?

Signed: _____

Print Name: _____

Contact Number: _____

Date: _____