DAY CAMP GIRL HEALTH RECORD

Name (Last, First, Initial)	Parent or Guardian		
Address	City	State	Zip

Mom's Home (____)__________	Dad's Home (____)__________	Date of Birth	Age	Sex
Mom's Cell (____)__________	Mom's Work (____)__________			Female
Dad's Cell (____)__________	Dad's Work (____)__________			Male

Emergency Contact Person & Relationship to Camper (Not yourself, we always try parents/guardian first!)	Home Phone (____)__________ Cell Phone (____)__________ Work Phone (____)__________

Allergies: No Known Allergies

To foods (list):

To medications (list):

To the environment (insect stings, hay fever, etc. – list):

Other allergies (list):

Describe previous reactions:

Diet, Nutrition: Eats a regular diet. This camper eats a regular vegetarian diet.
This camper has special food needs. (**Please describe below.)**

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.)**

Is the participant covered by family medical/hospital/prescription insurance? 0 Yes 0 No

Photocopy of front and back of all health insurance cards must be attached to this form.

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to engage in all prescribed activities, except as noted by me and/or the examining physician. I give permission to the physician selected by the camp and/or his designated associates 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. 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. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian ____ Date ______________

0 Wendv

0 Rock Hill

0 Rockv Brook

0 Birch Ridae

0 Addisone Bovce

Sian Here

Office Use Only

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Med HX 6th months	
Parent Signature	
Immuno HX	
Camper Confidential	
Insurance	

Office Use Only

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

Has/does the camper:

1.	Ever been hospitalized?	Yes	No
2.	Ever had surgery?	Yes	No
3.	Have recurrent/chronic illnesses?	Yes	No
4.	Had a recent infectious disease?	Yes	No
5.	Had a recent injury?	Yes	No
6.	Had asthma/wheezing/shortness of breath?	Yes	No
7.	Have diabetes?	Yes	No
8.	Had seizures?	Yes	No
9.	Had headaches?	Yes	No
10.	Wear glasses, contacts, or protective eyewear?	Yes	No
11.	Wear hearing aids or have hearing problems?	Yes	No
12.	Had fainting or dizziness?	Yes	No
13.	Passed out/had chest pain during exercise?	Yes	No
14.	Had mononucleosis ("mono") during the past 12 months?	Yes	No
15.	If female, have problems with periods/menstruation?	Yes	No
16.	Have a problem with falling asleep/sleep walking?	Yes	No
17.	Ever had back/joint problems?	Yes	No
18.	Have a history of bedwetting?	Yes	No
19.	Have problems with diarrhea/constipation?	Yes	No
20.	Have any skin problems?.	Yes	No
21.	Traveled outside the county in the past 9 months?	Yes	No

Please explain "Yes" answers in the space below, nothing the number of the questions. For travel outside the country, please name countries visited and dates of travel.

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

Has the camper:

A.	Ever been diagnosed with attention deficit disorder (ADD) or AD/HD?	0 Yes	0 No
B.	Ever been treated for emotional or behavioral difficulties or an eating disorder?	0 Yes	0 No
C.	During the past 12 months, seen a professional to address mental/emotional health concerns?	0 Yes	0 No
D.	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.)	0 Yes	0 No

Please explain "Yes" answers in the space below, nothing the number of the questions.
The camp may contact you for additional information.

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CAMPER CONFIDENTIAL TO BE FILLED OUT BY PARENT OR GUARDIAN

Two copies of this page are required; one is kept with the medical records and one given to the Unit Staff.

CAMPER'S FULL NAME: ____

Last First Middle

GRADE IN FALL: ______ CAMP PROGRAM: ______________________________

We earnestly desire to have our camp offer your child the happiest, most beneficial experience possible. Please answer the following questions regarding your child's interests and abilities.

1. Does your camper have any allergies (food, medication, insects, etc.)? ____________
2. Does your child have asthma? ____________
3. Does your camper have any food restrictions? ____________
4. What is your child's eating habits? ____________
5. Does your child have any fears? ____________
6. No. of brothers_________Ages_________No. of sisters_________Ages____________
7. What is your child's physical activity level? High _____ Medium _____ Low _____
8. Is your child easily frustrated? ____________
9. How does your child express emotions? ____________
10. What does sad look like? Frustrated? Mad? ____________

    ____
11. How does your child respond to change? ____________
12. Is your child sensitive to sight, sound or touch? ____________
13. Would you characterize your child as flexible? ____________
14. Is your child easily distracted? ____________
15. What are your child's special abilities? ____________
16. What are your child's hobbies? ____________
17. Does your child wet the bed? ____________

Please repeat on this page any items from your camper's health history that her councilors should be aware of. Be sure to include asthma, allergies, seizure disorders, medications, learning disabilities, behavioral patterns, emotional sensitivities, restricted mobility and any other pertinent information.

In what way did previous camp experience benefit your child?____________

____

What do you hope your child gains from her camp experiences this year?____________

____

Has any recent event affected your child in a way that might make her unhappy away from home? (such as death of a pet, parent away on long tip, impending or recent move, separation of parents, etc.) __________

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Additional Comments: ____________

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Relationship to camper: ________________________Signature________________________________

Immunization History: Provide the month and year for each immunization. Copies of immunization forms from health-care providers or state or local government are acceptable; please return with 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)							xxxxxxxxxxx
Tetanus booster* (dT) or (TdaP)		xxxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx	
Mumps, measles, rubella (MMR)				xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx	
Polio (IPV)						xxxxxxxxxxx	xxxxxxxxxxx
Haemophilus influenzae type B (HIB)						xxxxxxxxxxx	xxxxxxxxxxx
Pneumococcal (PCV)						xxxxxxxxxxx	xxxxxxxxxxx
Hepatitis B					xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx
Hepatitis A				xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx
Varicella (chicken pox)	Had disease Date:			xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx
Meningococcal meningitis			xxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx

***A Tetanus shot given within 10 years is required.**

Tuberculosis (TB) test	Date:	Negative	Positive