

Health Care Form for Children, Youth and Adults Attending Camp Friendship

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to Camp Friendship personnel upon participant's arrival in camp. PLEASE provide complete information so that the camp can be aware of your camper's needs.

Camper Name _____ Birth Date _____ Age _____
Last First Middle

Home Address _____
Street City State Zip

Custodial Parent/Guardian _____ Phone _____

Home Address _____
(if different from above) Street City State Zip

Business Address _____ Phone _____
Street City

Second Parent/Guardian/Emergency Contact _____ Phone _____

Home Address _____
(if different from above) Street City State Zip

Business Address _____ Phone _____
Street City

If not available in an emergency, notify _____

Relationship _____ Phone _____

Home Address _____
Street City State Zip

Insurance Information

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

If so, indicate carrier or plan name _____ Group # _____

► **Photocopy of front and back of health insurance card must be attached to this form.**

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to Camp Friendship to provide routine health care, administer prescribed medications, and seek emergency medical treatment including x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to Camp Friendship to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Friendship to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian or Adult Staffer _____

Printed Name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in Camp Friendship activities.

Signature of Minor or Adult Staffer _____ Date _____

For religious or other reasons I chose not to sign this, and do not authorize treatment for the participant listed above.

Signature of Parent/Guardian or Adult Staffer _____

Printed Name _____ Date _____



Camper Name _____ Birth Date _____ Age _____
Last First Middle

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep medications in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

<input type="checkbox"/> This person takes NO medications on a routine basis OR <input type="checkbox"/> This person takes medications as follows: Med #1 _____ Dosage _____ What Time? _____ Reason for taking _____ Med #1 _____ Dosage _____ What Time? _____ Reason for taking _____ Attach additional pages for more medications. Please identify any medications taken during the school year that participant does/may not take during summer:
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RESTRICTIONS (The following restrictions apply to this individual)

Does not eat: Red Meat Pork Dairy Products Poultry Seafood Eggs Wheat/Gluten Other
 (Please Describe) _____

Explain any restrictions to activity (what cannot be done, what adaptations or limitations are necessary)

ALLERGIES This person **has NO known allergies** OR This person **has the following allergies**

Food Medicine The environment (insect stings, hay fever, etc) Other _____

Please describe specifically what the participant is allergic to and the reaction seen _____

SUNCREEN I **give permission** OR I do **NOT give permission**

To the Camp Friendship counselors to apply sunscreen, provided by myself, to this participant.

SWIMMING ABILITY Can't swim Beginner Intermediate Advanced

GENERAL QUESTIONS (Explain "yes" answers below)

Has/does the participant:	Y	N	Y	N
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints?	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance at camp?	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (itching, rash, etc)?	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. If female, have an abnormal menstrual history?	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. Ever had an eating disorder?	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>
12. Ever had seizures?	<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"/>		

Please explain any "yes" answers, noting the number of the questions. _____



Camper Name _____ Birth Date _____ Age _____
Last First Middle

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 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 (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative <input type="checkbox"/> Positive
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WHICH OF THE FOLLOWING HAS THE PARTICIPANT HAD?

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

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

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

For staff use:	
Staff review _____ Date _____ Time _____	Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____	Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____	Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____	Staff review _____ Date _____ Time _____
Meds received _____	
Any needs identified _____	
Updates/additions to health history <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None required	



Authorization for Child Pick-Up

Camper Name _____ Birth Date _____ Age _____
Last First Middle

I give permission to any person named on this document as a parent, guardian, second parent, second guardian, or emergency contact to pick up this participant from Camp Friendship. I understand that I and any authorized persons must show appropriate identification (Camp Friendship Pick-Up Pass, driver's license, photo ID) to remove this participant from Camp Friendship.

ADDITIONAL AUTHORIZED PERSONS

- I do NOT authorize any additional people to pick-up this participant from Camp Friendship.
- I do authorize the following individuals to pick-up this participant from Camp Friendship (must be 18 years of age or older).

Name _____

Relationship _____ Phone _____

Name _____

Relationship _____ Phone _____

Signature of Parent/Guardian _____

Printed Name _____ Date _____