Camp Chen-A-Wanda Camper Health History Form

Please complete pages 1-3 and 5 and have your child's physician complete and sign page 4. **All forms must be completed and submitted along with copies of your child's health insurance cards by by June 1st for camp to give treatment.**

Name: ____
First Middle Last

Bunk: ___________ Dates of Attendance ___________ to __________
Mm/dd/yy mm/dd/yy

[ ] Male [ ] Female Date of Birth __________ Age as of 6/27/10 _____
Mm/dd/yy

Camper Home Address: ____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: ______________________ Relationship to Camper: ________________ Email: ________________________
Home: ( ) ___________________ Cell: ( ) ___________________ Work: ( ) ___________________
Home Address: ____
(if different from above) Street Address City State Zip Code

Second Parent/Guardian or other emergency contact:

Name: ______________________ Relationship to Camper: ________________ Email: ________________________
Home: ( ) ___________________ Cell: ( ) ___________________ Work: ( ) ___________________

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name: ______________________ Relationship to Camper: ________________ Email: ________________________
Home: ( ) ___________________ Cell: ( ) ___________________ Work: ( ) ___________________

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 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 ____________ Relationship to Camper: ________________________

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: ( ) ____________________

Allergies: [ ] No known allergies	Intolerance	Anaphylaxis	EpiPen
[ ] To Food (list): ______________________________	[ ]	[ ]	[ ]
[ ] To medication (list): ______________________________	[ ]	[ ]	[ ]
[ ] To environment (insect stings, hay fever, etc. list): __________________	[ ]	[ ]	[ ]
[ ] Other allergies (list): ______________________________	[ ]	[ ]	[ ]

Describe previous reactions: ____
____

Parents, please make sure your child is aware or his/her allergies as well as the severity and the course of action to be taken.

Restrictions: [ ] I have reviewed the program and activities of the camp and feel the camper can participate without restriction.
[ ] I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. **(Please describe)** ____
____

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

Camp Chen-A-Wanda Camper Health History Form

Name: ____ Bunk: ___________ Date of Birth _____________________

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach.

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, tetnus, pertusis * (Dtap) (TdaP)						
Tetnus booster * (dT) or (TdaP)						
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 being fully immunized.

Signature of Custodial Parent/Guardian: ______________________________ Date: _____________ Relationship to Camper: ____________________________

Medication: [ ] This camper will not take any daily medications while attending camp.
[ ] This camper will take daily medications while at camp.

If yes, fill out the Medication Submission Form and submit with needed medications.

Camp Chen-A-Wanda Camper Health History Form

Name: ____ Bunk: ___________ Date of Birth _____________________

Non-prescription medications: These will be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. Please indicate which can and cannot be used for your child. Both Generic and brand name medications are used in the Health Center. The determination of need for these medications will primarily be made by our RN staff or the MD on call and they will be administered according to the directions on the package.

	Can Use	Cannot Use		Can Use	Cannot Use
Advil	[ ]	[ ]	Aloe	[ ]	[ ]
Antibiotic Cream	[ ]	[ ]	Antihistamine/allergy medicine	[ ]	[ ]
Benadryl	[ ]	[ ]	Calamine Lotion	[ ]	[ ]
Elimite	[ ]	[ ]	Epinephrine (Epi-Pen)	[ ]	[ ]
Ex-Lax	[ ]	[ ]	Generic Cough Drops	[ ]	[ ]
Hydrocotisone cream	[ ]	[ ]	Kaopectate	[ ]	[ ]
Motrin	[ ]	[ ]	Nix	[ ]	[ ]
Pepto-Bismol	[ ]	[ ]	Robitussin	[ ]	[ ]
Robitussin DM	[ ]	[ ]	Sore throat spray	[ ]	[ ]
Sudafed	[ ]	[ ]	Sudafed PE	[ ]	[ ]
Tolnaftate	[ ]	[ ]	Tylenol	[ ]	[ ]

General Health History: Please check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

	Yes	No		Yes	No
1.Ever been hospitalized?	[ ]	[ ]	11. Had fainting or dizziness?	[ ]	[ ]
2.Ever had surgery?	[ ]	[ ]	12. Passed out/had chest pain during exercise?	[ ]	[ ]
3. Have recurrent/chronic illnesses?	[ ]	[ ]	13. Had mononucleosis during the past year?	[ ]	[ ]
4. Had a recent infectious disease?	[ ]	[ ]	14. If female, have problems with periods/menstruation	[ ]	[ ]
5. Had recent injury?	[ ]	[ ]	15. Have problems with falling asleep/sleepwalking?	[ ]	[ ]
6. Ever had back/joint problems?	[ ]	[ ]	16. Had asthma/wheezing/shortness of breath?	[ ]	[ ]
7. Have diabetes?	[ ]	[ ]	17. Have a history of bedwetting?	[ ]	[ ]
8. Had Seizures?	[ ]	[ ]	18. Have problems with diarrhea/constipation?	[ ]	[ ]
9. Had headaches?	[ ]	[ ]	19. Have any skin problems?	[ ]	[ ]
10. Require meds. for motion sickness?	[ ]	[ ]	20. Wear glasses, contacts, protective eyewear?	[ ]	[ ]
			21. Traveled outside the US within the past 9 months?	[ ]	[ ]

Please explain "Yes" answers. Note the question's number, and for travel outside of the US, please name countries visited and dates of travel. ____

____

____

____

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

Has the camper:	Yes	No
1.Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	[ ]	[ ]
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?	[ ]	[ ]
3. During the past 12 months, seen a professional to address mental/emotional health concerns?	[ ]	[ ]
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, other)	[ ]	[ ]

Please explain "Yes" answers. Note the question's number. The camp may contact you for additional information.

____

____

____

____

Parents/Guardians: STOP here. Please submit final page of form to your child's healthcare provider to be filled out and signed. No child may be seen by the camp health staff without proper medical forms. All forms must be submitted to the camp office no later than June 15th. Before June 1st, please mail forms to 1 Ellis Ct. Woodcliff Lake, NJ 07677 or fax to (201)391-2295. After June 1st, please mail forms to 355 Camp Rd. Thompson, PA 18465 or fax to (570)756-2086

Camp Chen-A-Wanda Camper Health History Form

Name: ____ Bunk: ___________ Date of Birth ______________________

Medical Personnel: Please review pages 1-3 of this form and complete page 4. Attach additional information if needed.

Physical exam done today: [ ] Yes Date: _______________ [ ] No Date of last physical: _____________________
Weight: _________ lbs Height: ________ ft ________ in Blood Pressure ________/___________
A physical exam must be completed within the 24 months prior to the camp season.

Allergies: [ ] No known allergies	Intolerance	Anaphylaxis	EpiPen
[ ] To Food (list): ____________________________________	[ ]	[ ]	[ ]
[ ] To medication (list): ____________________________________	[ ]	[ ]	[ ]
[ ] To environment (insect stings, hay fever, etc. 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 medical conditions: (describe below) [ ] None
____
____
____
____

Medication [ ] No daily medications [ ] will take the following prescribed medication(s) while at camp

Name	**Reason for Taking**	**Dose**	**How Given**	**Frequency**

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 (describe)
____
____

"I have reviewed the Camper Health History Form 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)"

Name of licensed provider (please print) ________________________ Signature ______________ Title ___________________

Office Address ____
Street City State Zip Code

Telephone: ( ) ___________________________________ Date: ____

Camp Chen-A-Wanda Camper Health History Form

Name: ____ ___ [ ] Male [ ] Female Date of Birth ______________
First Middle Last Mm/dd/yy
Camper Home Address: ____
Street Address City State Zip Code
Parent/guardian with legal custody to be contacted in case of illness or injury:
Name: _________________________ Relationship to Camper: __________________ Email: ___________________________
Home: ( ) ______________________ Cell: ( ) ______________________ Work: ( ) ______________________
Home Address: ____
(if different from above) Street Address City State Zip Code

Medical Insurance Information:
This camper is covered by family medical/hospital insurance [ ] Yes [ ] No Camper's Social Security # _____-____-_______
Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.
Insurance company ______________________________ Policy Number ____
Subscriber ____________________________________ Insurance Company Phone Number ( ) ____________________
Policy Holder's Social Security # _____-____-_______ Policy Holder's Contact Number ( ) _______________________

Attach Copy of Front of Insurance Card HERE	Attach Copy of Back of Insurance Card HERE

In the event that your child needs medical attention outside of camp, you will be notified by a member of our staff.

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Signature of Custodial Parent/Guardian ________________________________ Date _____________ Relationship to Camper: ___________________________

Allergies: [ ] No known allergies	Intolerance	Anaphylaxis	EpiPen
[ ] To Food (list): ____	[ ]	[ ]	[ ]
[ ] To medication (list): ____	[ ]	[ ]	[ ]
[ ] To environment (insect stings, hay fever, etc. list): ___________________	[ ]	[ ]	[ ]
[ ] Other allergies (list): ____	[ ]	[ ]	[ ]

Describe previous reactions: ____
____

Indicate any major illnesses, injuries or surgeries that cause camper to be hospitalized as well as **date** of hospitalization.
Please also include any medical conditions we should be aware of in the event that the camper needs to go to the hospital.
____
____