

**Please provide a copy for EACH camp attending - photocopies acceptable.**

# Health History Form for Youth Attending Camp

## DO NOT MAIL THIS FORM

**Do not pack in suitcase --HAND IN UPON ARRIVAL AT BUS/BOAT or CAMP.**

**Because of safety concerns, camper will NOT BE ADMITTED TO CAMP WITHOUT THIS FORM**



For Office Use

**Dear Parents/Guardians:** Camp will make every effort to contact you by phone if your camper becomes ill or injured. We prefer to involve you in decisions about every aspect of your camper's health, and will attempt to reach you for all but minor injuries and illnesses. We may also call you to consult about behavioral and emotional problems, homesickness, and other things your camper might experience, if we are unable to resolve the situation. Thank you for telling us all you can on this form about your camper... and please do not forget the Medication Information on page four (4). This information will be seen ONLY by camp staff and professional providers on a need-to-know basis.

**Please print**

**Camper Name:** \_\_\_\_\_  
Last Name First Name M I

Camp Use Only  
**Please**

**Address:** \_\_\_\_\_  
Street City State Zip Code

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Grade in Fall:** \_\_\_\_ **Age at Camp:** \_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ lbs.  Male  Female

**Where and how can you be reached DURING camp?**  
\_\_\_\_\_

### Emergency/Alternate Contacts

**Parent 1 Name (Custodial parent or Guardian):** \_\_\_\_\_

Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

Cell: ( ) \_\_\_\_\_ Pager: ( ) \_\_\_\_\_

**Parent 2 Name:** \_\_\_\_\_

Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

Cell: ( ) \_\_\_\_\_ Pager: ( ) \_\_\_\_\_

**Alternate Contact:** \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

Cell: ( ) \_\_\_\_\_ Pager: ( ) \_\_\_\_\_

**Camper's Physician:** \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**Camper's Dentist:** \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

<b>INSURANCE INFORMATION:</b>	Please provide the following, or a copy of insurance card (front and back).
Carrier: _____	Billing Address: _____
Subscriber Name: _____	Subscriber #: _____
Group #: _____	Med Copay \$ _____
ID# _____	Rx Copay(s) \$ _____

### Camp Authorization and Consent to Treatment

*(If for religious or other reasons you wish **not** to authorize treatment, please attach letter of explanation.)*

I attest that the camper is in good health and able to participate actively in camp activities except as noted in this form. I take full responsibility to see that the camper is properly prepared for camp including proper clothing and equipment and being in good health.

I authorize the camp to provide routine health care, administer prescribed and over-the-counter medications that I am sending to camp, as well as any medications recommended by the camp's physician for various problems except as I have noted on page three (3) of this Health Form. I authorize camp to share information provided with selected camp staff (counselor, health care, food service, etc.) and professional health care providers on a need-to-know basis. I agree to the release of any records necessary for treatment, referral billing, or insurance purposes.

In the case of medical emergency, I hereby give my permission to the physician secured by the camp to hospitalize, secure treatment for and to order injection, anesthesia, or surgery for my above named camper. I authorize the camp to arrange and/or provide necessary related transportation for the camper.

*I agree to be responsible for expenses incurred in the care and treatment of the camper. I understand that a photocopy of this authorization is to be considered as valid as the original.*

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Parent/Legal Guardian or Adult Camper/Staff

\_\_\_\_\_  
Printed Name Relationship to Minor Camper

**All campers with life-threatening health concerns or allergies must submit an Emergency Action Plan available from a physician. SUBMIT AT LEAST 3 WEEKS PRIOR TO ATTENDING CAMP to the Spokane Camp Fire office.**

**Medications and/or Care & Treatment**  
 [ See Med Info on Page 4 ]

**Known Allergies**

**Reactions**

Food: \_\_\_\_\_  
 Drugs: \_\_\_\_\_  
 Plants: \_\_\_\_\_  
 Insects: \_\_\_\_\_  
 Other: (Chemicals, Latex, Etc.) \_\_\_\_\_

Camper **DOES NOT** Eat:  Red Meat     Chicken     Fish     Milk/Diary     Other \_\_\_\_\_  
     Turkey     Pork     Eggs     Any Animal Products

Check if Camper is:     Gluten Intolerant     PKU     Lactose Intolerant     Other \_\_\_\_\_

Please explain any and all special needs and restrictions regarding camper's nutrition: (Attach additional sheet if necessary)

Please describe any and all restrictions to camper's activities while at camp: (Attach additional sheet if necessary.)

Will camper bring orthodontic appliance, contacts (hard or soft) and/or hearing aid to camp?

If so, what and instructions on care:

Explain severity, treatment and care or how we can help for the following: (Attach additional sheet if necessary.)

- \* Sleep disorder, sleep walking, nightmares, sleep noises, etc.
- \* Physical impairments, disabilities or mobility limitations
- \* Bedwetting (send Pull-ups or similar)
- \* If female, abnormal menstrual history

**General Questions (Explain "yes" answers below - Attach additional sheet if necessary.)**

Has/does your camper:	YES	NO	
1. Had any recent injury, illness, or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Had chicken pox?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Ever had problems with joints (e.g. knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Have any skin problems (e.g. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
18. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	_____
19. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	_____
20. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
21. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	_____
22. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
23. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
24. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	_____
25. Have Hepatitis A, B, or C? (Circle) A B C	<input type="checkbox"/>	<input type="checkbox"/>	_____

What works effectively for your camper to prevent sunburn? Please send this product with your camper to camp.

If your camper has head lice, may we shampoo with Nix (or other lice product) and remove nits (\*\*)?

Yes     No    If recently treated, when? \_\_\_\_\_

\*\*Day campers will be sent home for treatment.

**Camp Use Only**  
**Please**

**CAMPER NAME:** \_\_\_\_\_

Give the dates (year) of the last immunization or booster, or attach a copy of camper's OFFICIAL immunization record:

\_\_\_\_\_ Tetanus      \_\_\_\_\_ Chicken Pox      \_\_\_\_\_ Mumps      \_\_\_\_\_ Diphtheria/Pertussis (DTaP/DT)  
\_\_\_\_\_ Flu      \_\_\_\_\_ Measles/Rubella      \_\_\_\_\_ Hepatitis A      \_\_\_\_\_ Hepatitis B

Camp Use Only  
Please

Mental, Emotional, and Social Health - Check all that apply:

- Emotional Health Concern       ADHD       Attention Deficit Disorder (ADD)  
 Hyperactivity       OCD       Learning Disability  
 Behavior Management Issues      Psychiatric Diagnosis: \_\_\_\_\_

Describe severity and management plan (attach separate sheet to give details):

**3 WEEKS PRIOR TO ATTENDING CAMP:**

**Campers with severe behavioral issues must submit a Behavior Management Plan along with the Special Needs Assessment Form to the Spokane Camp Fire office**

Is the camper currently seeing a professional to address emotional/mental health concerns?       YES       NO

**The following are the over-the-counter (OTC) medications (or generic equivalent) we use for common ailments that arise at camp. These are recommended by the physician who oversees health care at camp. We are limited to dispensing only these medications without further permission from a physician/parent/guardian.**

Please cross off those OTC medications you ***DO NOT*** want the camp to administer.  
**UNLESS CROSSED OFF, PERMISSION IS GIVEN TO ADMINISTER THESE OTC MEDS.**

For pain, cough, cold:

- Tylenol or Aleve
- Ibuprofen
- Benadryl
- Chlor-Trimeton
- Robitussin
- Sudafed
- Claritin
- Cough Drops/Throat Lozenges
- Chloraseptic Spray

For Digestive Upsets:

- Tums
- Pepto Bismol
- Altoids or Peppermint
- Kaopectate
- Milk of Magnesia

For anaphylaxis - only in life-threatening emergencies:

- Epinephrine

Topical (skin) Products:

- Insect Repellent (with DEET)
- Sunscreen (paba free)
- Aloe Vera plant or gel
- Calamine or Caladryl Lotion
- Skin Moisturizer
- Baking Soda or Meat Tenderizer Paste
- 1% Hydrocortisone Cream
- Antibiotic ointment
- Gold Bond Medicated Powder
- Athlete's Foot Powder

Medications taken during school year that camper is NOT to take during camp (\*):

*\*Send some of the medication to the camp in case it becomes necessary - follow stated policy below.*

**Attention: Important medication information**

1. Send enough to last the entire time the camper will be at camp including prescription & over-the-counter meds, vitamins, and ANYTHING else taken regularly by the camper.
2. Siblings MUST each have individual prescriptions - No exceptions.
3. Expired medications are PROHIBITED.
4. Over-the-counter meds & vitamins that identifies dosage, frequency of administration and patient.
5. Parent instructions that vary from prescription medication bottle or physician instructions are NOT accepted.

**All prescribed medications MUST have:**

1. Prescribing Physician
2. Camper's name
3. Name of medication
4. Directions for dosage and administration from pharmacy or official form - in ENGLISH - from physician.

**ALL OVER-THE-COUNTER AND PRESCRIPTION MEDICATION/VITAMINS MUST BE IN THE ORIGINAL PACKAGE AND/OR BOTTLE!**

***Please put medications & dosage for meds/vitamins being brought to camp on page 4.***

**Medical Examination Form To Be Completed By Physician - optional**

We recommend but do not require that campers have a medical examination and physician's authorization within 24 months prior to attending camp. You may also attach a copy of a school or sports physical examination record.

Physician's Statement      Camper's Name: \_\_\_\_\_

I find the camper to be in good health and able to take part in outdoor activities at Camp with the following exceptions:

Comments on camper's health:

Conditions that require special consideration (please attach management plan for any chronic illnesses, etc.)

Date of Examination: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_

Address: \_\_\_\_\_

City, St, Zip: \_\_\_\_\_

# Medication Record

Camper: \_\_\_\_\_

**Parent/Guardian:** Please print. Please complete for all meds (Rx, OTC, and vitamins). Include dosage & check or insert times of administration. If you are sending meds taken during school year but not at camp, please check this box.

PLEASE PUT LABELED MEDICATIONS/VITAMINS IN ONE ZIPLOCK® BAG, LABELED WITH CAMPERS NAME. TURN IN WHEN YOU CHECK-IN AT BUS/BOAT.  
 (Parents complete this section only!) (Please leave days blank for camp use only)

	Medication	Times	✓	🕒		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
Parents complete this section only.	Med:	Breakfast			D a y  s e c t i o n  f o r  c a m p  u s e  o n l y								
		Lunch											
	Dosage:	Dinner											
		Bedtime											
	Med:	Breakfast											
		Lunch											
	Dosage:	Dinner											
		Bedtime											
	Med:	Breakfast											
		Lunch											
	Dosage:	Dinner											
		Bedtime											
Med:	Breakfast												
	Lunch												
Dosage:	Dinner												
	Bedtime												
Med:	Breakfast												
	Lunch												
Dosage:	Dinner												
	Bedtime												
Med:	Breakfast												
	Lunch												
Dosage:	Dinner												
	Bedtime												

## Health Care Treatment

Date	Time	Initials	Complaint/Condition	Treatment

Staff Signatures: \_\_\_\_\_ Initials: \_\_\_\_\_ Staff Signatures: \_\_\_\_\_ Initials: \_\_\_\_\_

Review Record (For camp use only)	Date Received: _____	Reviewed By: _____
Meds Received by: _____	Date Received: _____	Date Reviewed: _____