

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

american **CAMP** association®

Mail this form to the address below by 05/13/2022 (date)

The Barn at Spring Brook Farm
360 Locust Grove Rd
West Chester, PA 19382

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last

Male Female Birth Date _____ Age on arrival at camp: _____
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

- 1) Complete **pages 1, 2 and 3** of this form (**FORM 1**) and **make a copy**.
- 2) Send the **original, signed FORM 1** to camp by the requested date.
- 3) Complete the top of **FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS)** and provide the **copy of FORM 1 with FORM 2** to your **child's health-care provider** for review and completion.
- 4) After it has been **completed and signed** by your child's health-care provider, return **FORM 2** to camp by the requested date.

Camper Name
First

Middle

Last

(For Camp Use) Cabin or Group

(For Camp Use) Session Code(s):

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: _____ Preferred Phones: (_____) (_____) _____
Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:
Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) (_____) _____
Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:
Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) (_____) _____

Allergies: No known allergies. This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.)
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: This camper eats a regular diet. This camper eats a regular vegetarian diet. This camper is lactose intolerant. This camper is gluten intolerant.
 Other, *please explain in space.*

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.)

Medical Insurance Information:
This camper is covered by family medical/hospital insurance Yes No
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 (_____) _____

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 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. 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: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

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Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred () immunizations must include date to meet ACA Standard. 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)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative <input type="checkbox"/> Positive
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If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not 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 the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.**

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

Camp Geronimo does not carry over-the-counter medications. All medication needs to come with the camper and must include a physician order.

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Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

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

Has/does the camper:

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

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

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

Has the camper:

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

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): _____	Phone: (____) _____
Name of dentist(s): _____	Phone: (____) _____
Name of orthodontist(s): _____	Phone: (____) _____

What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. **Attach additional information if needed.**

Parents/Guardians: STOP here. The rest of this form is completed when the camper arrives at camp. Keep a copy for your records.

