

Health History and Information Form

Camp Session _____
Date of Session _____

The following health information and history is used by the camp's healthcare provider in identifying appropriate health care for the participant. Physicals are not required for participants, unless he/she is currently under the care of a physician for an existing health issue. Please complete pages 1-4 as completely as possible and bring to camp on the day of registration. If you have any questions while filling out the form call the camp office at 574-658-4831.

Personal Information

A) Camper Name _____ Birth Date _____ Male Female
Last First Middle Gender

Address _____
Street Address/ P O Box City State Zip

B) Parent/Guardian _____ Preferred Phone Number _____
 Home Phone Work Phone Cell Phone

Address _____
Street Address/ P O Box City State Zip

Business Address _____ Business Phone _____

C) Additional Contact Person _____ Preferred Phone Number _____
Relationship _____ Home Phone Work Phone Cell Phone

Address _____
Street Address/ P O Box City State Zip

Business Address _____ Business Phone _____

D) In an emergency, if persons listed in A, B, and C are not available, notify:

Name _____ Relationship _____ Phone _____

Address _____
Street Address/ P O Box City State Zip

Insurance Information Primary health and accident insurance coverage is through the participant's family. Secondary health and accident insurance coverage is through Camp Mack.

Social Security Number of participant # _____

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

If yes, indicate the insurance carrier or plan name and policy number _____ Group # _____

It is requested that a copy of the insurance card be provided for accuracy.

Important – This information in this box must be completed for participation

Parent/Guardian/Staff Authorization: The personal information and following health history is correct and complete as far as I know. The person described has my permission to engage in all camp activities as noted.

I give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event that I cannot be reached in an emergency, I give permission to the physician selected by the camp 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, adult camper or staff _____

Health History and Information

Camper Name _____

The following information must be completed by the parent/guardian, adult camper, or staff member. This information will provide camp health care staff information for providing appropriate health care. Any changes in the information provided on this form should be provided to the camp health care staff upon the participant's arrival at camp. You are encouraged to be as complete as possible so that the camp can be aware of the camper's needs. Keep a copy of this form for your records.

A) ALLERGIES

- The participant has no known allergies.
- The participant is allergic to this medication/s:

Medication allergies	This causes anaphylaxis?	Describe reaction and management of the reaction
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

- The participant has the following food allergies:

Food Allergies	This causes anaphylaxis?	Describe reaction and management of the reaction
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

- The participant has the allergies not noted above:
Other Allergies – include insect bites, stings, hay fever, etc.

_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

B) NUTRITION

We can work effectively with some medically prescribed diets, but it may be necessary in some situations for the participant to bring special foods for certain diets.

- The participant eats a regular, varied diet.
- The participant is a vegetarian of this type: Semi-Vegetarian (no red meats) Vegan (no meats, eggs, or dairy)
 Pesco (no pork, beef, or chicken) Lacto-ovo (no beef, pork, chicken, seafood, or fish)
- The participant is lactose intolerant
- The participant responds with an anaphylactic reaction when this food is eaten: _____
- The participant is on the following medically prescribed diet: _____

Camper Name _____

C) CHRONIC CONCERNS: Check all items that pertain to the participant and provide information about supportive health care.

- Participant has no chronic health concerns.
 Participant has the following chronic health concerns:
- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Sleep Problem/Walking | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Difficult breathing | <input type="checkbox"/> Fainting | <input type="checkbox"/> Surgery history | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Back Pain or Injury | <input type="checkbox"/> Knee or ankle weakness | <input type="checkbox"/> Seasonal Allergy | <input type="checkbox"/> Bed wetting |

Other: _____
 Provide information about supportive healthcare needed for each checked item: _____

D) IMMUNIZATION HISTORY Provide the month and year for immunizations as possible. Starred (*) items must be current.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4
DTP: Diphtheria, Tetanus, Pertusis				
*TD: Tetanus Booster				
*IVP/OPV: Polio				
*MMR: Measles, Mumps, Rubella				
Hep B: Hepatitis B				
Hib: H Influenza, Type b				

E) MEDICATIONS

Please list ALL medications (including over-the-counter or non-prescription drugs and vitamins) being taken routinely. Bring enough medication to last the entire time at camp. Prescriptions meds MUST be in the pharmacy containers with appropriate labels. All other remedies must be in the original container.

- The participant takes NO medication on a routine basis.
 The participant takes routine medication (including vitamins) as follows (attach more information as necessary):

Med # 1 _____	Dosage _____	Specific times taken each day _____
Med # 2 _____	Dosage _____	Specific times taken each day _____
Med # 3 _____	Dosage _____	Specific times taken each day _____
Med # 4 _____	Dosage _____	Specific times taken each day _____
Identify any medications taken during the school year that the participant does/may not take during the summer. _____		

Note: The dosing schedules for some medications may be based on a daily school schedule. It is therefore recommended that a consultation be held with the prescribing physician to determine if the current dosing schedule is appropriate for the daily camp schedule. A typical daily schedule can be supplied if needed.

<i>To be completed only if participant is under the care of a physician for an existing ailment or condition</i>	
The applicant is under care for the following: _____	
The applicant <input type="checkbox"/> is <input type="checkbox"/> is not able to participate in an active camp program.	
_____	_____
Signature of Medical Personnel	Date

Camper Name _____

F) GENERAL PHYSICAL HISTORY

Has/does the participant:	Yes	No	Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have a chronic or recurring illness/condition?....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever been knocked unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Wear glasses, <u>contacts</u> , or protective eyewear?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever had frequent ear infections?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Ever passed out during or after exercise? ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever been dizzy during or after exercise?...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever had chest pain during or after exercise? ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever had heat or muscle cramps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever had problems with arm or leg joints? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have an orthodontic appliance being brought to camp?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have skin problems?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have any problems with teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Had chicken pox or immunized for chicken pox?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have problems sleep walking?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. If female, have begun menstruation?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If female, have an abnormal menstrual history?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers, noting the question number.

Does the participant have any piercings? Yes No
If so, where? Ears Eyebrow Nose Tongue Belly Button
Other _____

Has the participant been in countries other than the United States in the past nine months? Yes No
Country: _____ Dates _____
Country: _____ Dates _____
Country: _____ Dates _____

G) MENTAL AND EMOTIONAL HEALTH

Has the participant been diagnosed with attention deficit disorder (ADD) or (AD/HD)? Yes No
Has the participant been diagnosed with depression, OCD, panic/anxiety disorder? Yes No
Does the participant have an eating disorder? Type _____ Yes No
Does the participant have an emotional health concern?..... Yes No
Have there been any changes in the participant's mental health in the past month? Yes No
Explain _____

Does the participant's mental health lead to physical or emotional behavioral problems? Yes No
If yes, how has this behavior been managed most effectively? _____

Use this space to provide additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware (recent divorce issues, deaths in family or friends, or other trauma).

Name of Family Physician _____ Phone () _____

Address _____

Name of Family Dentist/Orthodontist _____ Phone () _____

Address _____