For Camp Use Only

Event #: ______________
Housing: _____________
Counselor:____________

CAMPER HEALTH HISTORY FORM (On-Site)

(This form needs to be completed and signed by Parent/Guardian; please print or type all entries)
Completed/Signed form must be brought to camp registration – PLEASE DO NOT MAIL.

GENERAL INFORMATION

CAMPER'S NAME: ____ Name Preferred: _________________________
Last First MI

Date of Birth: _____/_____/_____ Age: _____ Gender: M F Grade completed by June '10: _____ Height: _____ Weight: _____

Address: ____ City:_______________________ State:_____ Zip:__________

Name of Parent/Guardian: _____________________________________ Home Phone: (_____)___________________________

Parent/Guardian Work Phone: Mother: (_____)________________________ Father: (_____)___________________________

Cell Phone: Mother: (_____)________________________ Father: (_____)___________________________

IN CASE OF EMERGENCY, PLEASE NOTIFY (indicate, by number, the order desired: 1st, 2nd, 3rd)

( ) Parent/ Guardian named above
( ) __________________________________ Relationship to camper: ______________ Phone: (_____)________________
( ) __________________________________ Relationship to camper: ______________ Phone: (_____)________________

PHYSICIAN'S NAME: ____ Phone: (_____)________________
(Please Print)

Family Medical/Hospitalization Insurance: ____

Policy ID #: _______________________ Policy/Group #: _______________________ Policy Holder SS #: ______-____-________

Note: Campers are covered by limited accident and medical insurance as a secondary policy – only after personal insurance has been applied.

ILLNESSES AND INJURIES: Has the camper ever had any of the following illnesses or diseases? Please check those that apply.

____ Asthma ____Bleeding/Clotting Disorder ____ Chicken Pox ____Convulsions/Seizures
____ Diabetes ____Frequent Ear Infections ____Hypertension ____ADD/ADHD
____ HIV ____Frequent Sore Throats ____Heart Disease/Defect ____ Sickle Cell Disease
____ Kidney Disease ____Tuberculosis ____Frequent Upper Respiratory Infections
____Other (Specify) ____

DATE OF CAMPER'S LAST HEALTH EXAM WITHIN THE PAST 24 MONTHS _____/_____/_____

Were any problems noted at that time? ____

Is camper currently under a physician's care for a medical problem? No / Yes (describe)________________________________

Since camper's last health exam, has he/she had:

____ A serious injury requiring medical attention? Date: _____/_____/_____ What? ______________________________
____ A surgical operation or fracture? Date: _____/_____/_____ What? ______________________________
____ A diagnosed infectious/communicable disease? Date: _____/_____/_____ Disease: ______________________________
____ Medication prescribed by a physician? Date: _____/_____/_____What? ______________________________
____ A physician's restriction from participating in any school/camp physical activity? ______________________________

NOTE: A written statement from the camper's physician may be needed in order for your child to participate in strenuous camp activities such as swimming, boating, hiking, challenge course, or sports if you checked any of the above questions.

ALLERGIES (Please check those that apply.)

____Animals ____Seasonal/Environmental ____Foods (Specify) ________________________________

____Medications ____Insect Stings ____Plants (Poison Ivy, etc) ____Other (Specify)__________

Please explain any allergies checked above and list treatment if any is necessary:____

____

IMMUNIZATIONS

Are all immunizations up to date? Yes / No (describe) ____

Date of last Tetanus Shot (DPT, DT, TT) **MUST** be listed here _____/_____/_____

OTHER HEALTH CONDITIONS (Check those that apply)

___ Athlete's Foot ___ Bed Wetting ___ Constipation ___ Ear Tubes (How protected)

___ Emotional Problems ___ Fainting ___ Hearing Impairment ___ Homesickness

___ Menstrual Cramps ___ Motion Sickness ___ Nosebleeds ___ Ringworm

___ Sleepwalking ___ Stomach Upsets ___ Wears Glasses/Contacts ___ Special Dietary Regimen

Please explain any of above checked items or other conditions requiring medication, treatment or special restrictions or conditions while at camp.

____

____

CAMPER MEDICATIONS

ALL camper medications must be checked by the Camp Health Supervisor upon arrival. For these purposes, **Medication** is broadly defined to include all prescription and non-prescription medications, home remedies, vitamins, inhalers, drops, and medicated creams. The Health Care Supervisor will insure that medications are administered in accordance with physician's instructions. We ask your full cooperation in this matter so that every camper's health and well-being can be properly safeguarded.

Please complete one **'Authorization For Medication Administration'** form for each medication brought to camp. (You may copy the form.)

MEDICATIONS BROUGHT TO CAMP WILL NOT BE ADMINISTERED WITHOUT THIS COMPLETED MEDICATION FORM!

Limited types of common over-the-counter medications are available at camp and will be administered in accordance with standard procedures unless you request that your child not be given over-the-counter medication by checking this box.

Please Check One: ☐ I give permission to administer over-the-counter medications to this camper.

☐ Please seek approval from emergency contact person before administering over-the-counter medications.

CERTIFICATION AND AUTHORIZATION

I certify that the information provided on this Camper Health History Form is, to the best of my knowledge, complete and accurate. I know of no reason(s), other than the information indicated on this form, why my son/daughter should not participate in all camp activities. I take full responsibility for any medical problems (illness/injury) that occur as a result of my failure to disclose medical condition, restrictions, or limitations of my child. I understand the State of Pennsylvania requirement that a Health Care Supervisor examine all campers on the day of registration, and give my permission for the conduct of such an examination.

My son/daughter ____ has permission to participate in the activities associated with the summer camping program of Gretna Glen Camp. Additionally, I hereby give permission to the medical personnel selected by the Director to provide routine health care; to administer medications including those listed on the Authorization for Medication Administration form and common over-the-counter medications; to order X-rays, routine tests, and treatment; to release any records necessary for insurance purposes (this completed form may be photocopied for trips out of camp); and to provide or arrange necessary related transportation for my child in the event of an illness or emergency. In such an event, the Director, or designee, is authorized to act in my behalf in securing medical treatment, including hospitalization, for my child named above.

Signature of Parent/Guardian:____ **Date:** _____/_____/_____

Gretna Glen Camp is in compliance with the Health Insurance Portability and Accountability Act of 1996(HIPAA).

FOR CAMP USE ONLY-ON-SITE HEALTH EXAMINATION

General Health Condition: Poor, Good, Excellent: ____

Authorization for Medication Administration Form? Yes No

Illness experienced or exposed to during preceding 30 days (fever 103°, vomiting, altercation, communicable disease, etc.):

____

Recommendations and restrictions (activity, diet, etc.): ____

Signature of Camp Health Supervisor: ____ Date: _____/_____/_____