

For Camp Use Only

Camp#: \_\_\_\_\_

Housing: \_\_\_\_\_

Counselor: \_\_\_\_\_

# CAMPER HEALTH HISTORY FORM

Please bring completed/signed form with you to camp at check in – **PLEASE DO NOT MAIL.**

(PLEASE PRINT OR TYPE)

CAMPER'S NAME: \_\_\_\_\_ Name Preferred: \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Gender: M F Grade completed by June '12: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Parent/Guardian Work Phone: Mother: (\_\_\_\_) \_\_\_\_\_ Father: (\_\_\_\_) \_\_\_\_\_

Cell Phone: Mother cell: (\_\_\_\_) \_\_\_\_\_ Father cell: (\_\_\_\_) \_\_\_\_\_

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

- ( ) 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 #: \_\_\_\_\_

**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 what happens when they are exposed to any checked above:

\_\_\_\_\_

List treatments to any checked above.

**IMMUNIZATIONS**

Are all immunizations up to date? Yes / No (if 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**

**Please complete 'Authorization For Medication Administration' form for any medications brought from home.**

**ALL camper medications brought from home will be checked by the Camp Health Supervisor upon arrival.**

The Health Care Supervisor will insure that medications are administered in accordance with physician's instructions.

For these purposes, **Medication** is broadly defined to include prescription and non-prescription medications, home remedies, vitamins, inhalers, drops, and medicated creams.

**Medications brought from home will NOT be given without a complete Authorization Form**

- Limited types of common over-the-counter medications for treatment of pain, allergy, insect bites, and gastrointestinal upset will be administered by the health care provider as per our Doctor's standing orders. We ask your full cooperation in this matter so that every camper's health and well being can be properly safeguarded.

**\*\*IMPORTANT – THIS BOX MUST BE COMPLETED FOR ATTENDANCE\*\***

**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.): \_\_\_\_\_

Counselor advised of any above conditions: \_\_\_\_\_

Signature of Camp Health Supervisor: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_