CAMPER HEALTH HISTORY FORM 1

Please Print All Information

This form must be returned by **August 11** to
Alfond Youth Center
126 North St.
Waterville, ME 04901

Questions please call:
207-873-0684

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

Camper Name: ____
First Name Middle Last

☐ M ☐ F Birth Date: _____/_____/_____ Age on arrival at camp __________
Month Day Year

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To Parents(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).
2. Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) on page 4 and provide FORM 1 with FORM 2 to your child's health-care provider for review and completion.
3. After it has been completed and signed by your child's health care provider, return FORM 1 and Form 2 to camp by August 11, 2017.

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) cannot be reached:

Name ______________________ Relationship to Camper ______________ Preferred Phones (_____) ______________________

Email ______________________ (_____) ______________________

Allergies: ☐ No known allergies ☐ This camper is allergic to ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(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 has special food needs **(Please describe below – attach additional information if necessary)**

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 care 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 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 or 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 HEALTH HISTORY FORM 1
Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Camper Name _____
First Middle Last

Birth Date _____/_____/_____
Month Day Year

Immunization History: Provide the month & year for immunizations. Starred (*) immunizations must be current. 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 (PCB)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative	☐ Positive

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 or 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
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other time: _____		
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other time: _____		
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other time: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those the camper should not be given.**

Acetaminophen (Tylenol)
Aloe
Antibiotic cream, topical
Antihistamine/allergy medicine
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)
Calamine lotion
Chlorpheniramine maleate
Dextromethorphan cough syrup (Robitussin DM)
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Epinephrine
Generic cough drops
Guaifenesin cough syrup (Robitussin)
Hydrocortisone Cream
Ibuprophen (Advil, Motrin)
Ivy Dry
Laxatives for constipation (Ex-Lax)
Lice shampoo or cream (Nix or Elimite)
Phenylephrine decongestant (Sudafed PE)
Pseudoephedrine decongestant (Sudafed)
Silver Sulfadiazine
Sore throat spray
Tolnaftate

CAMPER HEALTH HISTORY FORM 1
Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

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 the countries visited and dates of travel.

Country: _____ Dates: _____/_____/_____ to _____/_____/_____
Country: _____ Dates: _____/_____/_____ to _____/_____/_____
Country: _____ Dates: _____/_____/_____ to _____/_____/_____

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

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? □Yes □No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

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 your 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**.

Rev. 1/2007 LEE/EAW

CAMPER HEALTHCARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL FORM 2

This form must be returned by **August 11** to
Alfond Youth Center
126 North St.
Waterville, Me 04901

Questions please call:
207-873-0684

To Parents(s)/Guardian(s): Complete this section and give **this form (FORM 2) and** a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review.

Dates will attend camp: _____/_____/_____ (Month Day Year) to _____/_____/_____ (Month Day Year)

Camper Name: _____ (First Name Middle Last)

☐ M ☐ F Birth Date: _____/_____/_____ (Month Day Year) Age on arrival at camp _____

Camper Home Address:

_____ (Street Address City State Zip Code)

Custodial parent(s)/guardian(s) telephone: (_____) _____

PARENT(S)/GUARDIAN(S) STOP HERE. REST OF FORM TO BE COMPLETED BY MEDICAL PERSONNEL.

The following non-prescription medications are commonly stocked in our camp's Health Center and will be used on an as needed basis to manage illness and/or injury.
Medical personnel:
CROSS OUT those items the camper should not be given...

Acetaminophen (Tylenol)
Aloe
Antibiotic cream, topical
Antihistamine/allergy medicine
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)
Calamine lotion
Chlorpheniramine maleate
Dextromethorphan cough syrup (Robitussin DM)
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Epinephrine
Generic cough drops
Guaifenesin cough syrup (Robitussin)
Hydrocortisone Cream
Ibuprophen (Advil, Motrin)
Ivy Dry
Laxatives for constipation (Ex-Lax)
Lice shampoo or cream (Nix or Elimite)
Phenylephrine decongestant (Sudafed PE)
Pseudoephedrine decongestant (Sudafed)
Silver Sulfadiazine
Sore throat spray
Tolnaftate

Physical exam done today: □ Yes □ No (If no, date of last physical _____/_____/_____ (Month Day Year))

ACA accreditation standards specify physical exam within last 24 months.

Weight _____ lbs Height _____ft _____ in Blood Pressure _____/_____

Allergies: ☐ No known allergies

☐ Food ***(list)***

☐ Medicine ***(list)***

☐ The environment (insect stings, hay fever, etc.) ***(list)***

☐ Other ***(list)***

Describe previous reactions:

Diet, Nutrition: ☐ This camper eats a regular diet ☐ Has a medically prescribed meal plan or dietary restrictions: (**describe below)**

This camper is undergoing treatment at this time for the following conditions: (describe below). ☐ None

Medication: ☐ No daily medications ☐ Will take the following prescribed daily medication(s) while at camp. **(name, dose, frequency – describe below)**

Other treatments/therapies to be continued at camp: (describe below) ☐ None needed

Do you feel that the camper will require limitations or restrictions to activity while at camp? □ No □ Yes

If you answered "Yes" to the question above, what do you recommend? (describe below – attach additional information if needed)

"I have reviewed the CAMPER HEALTH HISTORY FORMS (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Name of licensed provider (please print): _____ Signature _____ Title _____

Office Address _____ (Street Address City State Zip Code)

Telephone (_____) _____ Date _____/_____/_____

Rev. 2/2007 LEE/EAW