

FOR IONIAN VILLAGE OFFICE USE ONLY:

Cabin Name/Number _____ Session _____ Name _____
 Counselors _____ Notes _____

CAMPER HEALTH HISTORY FORM

Pages 1- 4 are to be completed by parent/guardian and reviewed by the health care provider at the time of examination. This form is used to help camp medical staff in determining appropriate care. This information will be shared on a "need to know" basis with Camp Staff. **Please keep a copy for your records, and mail the ORIGINAL to our office.**

Emergency Contact Information

Camper Name _____
Last First Middle

Home Address _____ Phone _____
Street City State Zip Area Code/Phone

Birth Date _____ Age _____ Gender _____

Parent/Guardian Name _____ Phone _____
Area Code/Phone

Home Address _____ Cell _____
Street City State Zip Area Code/Phone

Business Address _____ Phone _____
Street City State Zip Area Code/Phone

Other Parent/Guardian Name _____ Phone _____
Area Code/Phone

Home Address _____ Cell _____
(If different from above) Street City State Zip Area Code/Phone

Business Address _____ Phone _____
Street City State Zip Area Code/Phone

If parent and other parent/guardian are not available in an emergency, please notify:

Name _____ Relationship _____

Address _____ Phone _____
Street City State Zip

Name of Family Physician _____ Phone _____

Immunization History *(Provide the month and year for each immunization. Starred (*) MUST be current.*

Copies from health-care providers are acceptable (please attach to this form).

- Diphtheria, tetanus, pertussis* _____
- Tetanus booster* _____
- Mumps, measles, rubella* _____
- Polio* _____
- Haemophilus influenzae type B _____

- Hepatitis B _____
- Hepatitis A _____
- Varicella (chicken pox) _____
- Menigococcal meningitis _____
- Tuberculosis (tb) test _____

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.

CAMPER HEALTH HISTORY FORM

Insurance Information

Does the participant have family medical/hospital insurance? Yes No

Carrier _____ Policy or Group # _____

Name of Policy Holder _____ Relation to Participant _____

SS # of Policy Holder or Insurance ID Number _____

A copy of the Insurance Card
must be attached here.

Front of Card

A copy of the Insurance Card
must be attached here.

Back of Card

IMPORTANT— PLEASE READ CAREFULLY AND SIGN

Parent or Guardian Consent: This health history is correct and complete to my knowledge. The person described has permission to participate in all camp activities except as noted. I give permission to photocopy this form. I hereby give permission to the camp to obtain relevant 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 for the camp to arrange related transportation for my child. The purpose of onsite camp medical staff is solely for administering medications and performing triage and minor first-aid. In the event that I cannot be reached in an emergency, I hereby give permission to the health care provider selected by the camp to secure and administer treatment, including hospitalization.

Parents/guardians are responsible for ALL medical bills incurred while at camp (doctor visits, emergency room visits, and prescriptions). All attempts will be made to contact parent/guardian before taking the camper for "off camp medical care." A description of care received will be given to the parent.

Signature of Custodial Parent/Guardian:

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? 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.

CAMPER HEALTH HISTORY FORM

To be completed by Parent/Guardian

GENERAL HEALTH HISTORY Participant has or has had any of the following: (Please check if YES.)

Recent injury, illness, infection	_____	Joint problems	_____
Chronic illness/condition	_____	Back problems	_____
Surgery	_____	Skin problems (i.e. rash, acne)	_____
Frequent headaches/migraines	_____	Mononucleosis in the last 6 months	_____
Recent head injury	_____	Asthma	_____
Heart murmur	_____	Diarrhea/constipation	_____
Diabetes	_____	Sleepwalking	_____
Glasses, contacts	_____	Orthodontic appliances	_____
Frequent ear infections	_____	Significant emotional difficulties	_____
Passed out during or after exercise	_____	Bed-wetting	_____
Dizzy during or after exercise	_____	Eating disorder	_____
High blood pressure	_____	Other _____	_____

Please explain any "yes" answers:

IF FEMALE (Please answer YES or NO.)

Has this person menstruated? _____ If not, has she been told about it? _____ Is her menstrual history normal? _____

ALLERGIES (list all known) Describe the reaction and management of the reaction.

Medication Allergies (list) _____

Food Allergies (list) - (i.e. Nuts, lactose intolerance, shellfish, etc.) _____

Other Allergies (list) - (i.e. insect stings, hay fever, asthma, animal, plant, etc.) _____

RECOMENDATIONS AND RESTRICTIONS Explain what limitations are necessary.

Dietary (i.e. vegetarian): no restriction restriction: _____

Physical Activity: no restriction restriction: _____

Swimming/Diving: no restriction restriction: _____
 (Is capable of swimming the deep end of the pool?) yes no uncertain (Certified lifeguard will evaluate.)

Other restrictions: _____

CAMPER HEALTH HISTORY FORM

MEDICATIONS BEING TAKEN Please list all prescription and non-prescription medications taken on a regular basis. Please keep in original bottles labeled with health care provider's name, phone number, dosage and instructions. **Place all medicines in one plastic Ziploc bag and label with camper's name.**

Note: It is camp policy that all medications will be kept and secured at the Camp Infirmary. This includes vitamins/supplements and medications taken on an "as needed basis." The only medicines that may be left in cabins are creams and inhalers.

Please attach additional pages for more medications. Make sure to notify the medical staff when you arrive at camp if additional medications have been added after the health form was filled out.

- 1) Med _____ Dosage _____ Specific times per day _____
Reason for taking _____
- 2) Med _____ Dosage _____ Specific times per day _____
Reason for taking _____
- 3) Med _____ Dosage _____ Specific times per day _____
Reason for taking _____

The following non-prescription medications may be given to my child, if needed: (Please circle YES or NO)

Tylenol/acetaminophen	YES	NO	Decongestant	YES	NO
Advil/ibuprofen	YES	NO	Benadryl	YES	NO
Cough syrup, lozenges, throat spray	YES	NO	External ointments, sprays, lotions	YES	NO
Antacid	YES	NO	Pepto Bismol	YES	NO
Imodium	YES	NO	Other medications per discretion of camp medical staff	YES	NO

TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER

I examined this individual on _____ (Exam must be performed within 12 months of camp attendance.)

BP _____ Weight _____ Height _____

I have personally reviewed the above health information and activity restrictions and have made any necessary corrections or additions.

Signature of Licensed Health Care Provider _____

Name (printed) _____ Title _____

Address _____

Phone _____ Date _____

CAMP SCREENING RECORD (FOR CAMP USE ONLY)

Meds received _____

Current health needs identified _____

Observational notes _____

Screened by _____ Date _____