

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

2010 Session: 1st 6/26 to 7/23 FULL 6/26 to 8/15 2nd 7/25 to 8/15

Camper Name: _____
Last Middle First

Male Female Birth Date _____ Age on arrival at camp _____

**Please Mail this form by May 1st, 2010 to
Pierce Camp Birchmont
37 Mineola Avenue
Roslyn, NY 11576**

**After June 1st
Pierce Camp Birchmont
693 Gov. John Wentworth Highway
Wolfeboro NH 03894**

**After June 1st
Please fax a copy to 603-569-5813**

To Parent(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) and make a copy.
- 2) Send the original, signed FORM 1 to camp by the requested date.
- 3) Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.
ALSO please fill out the back of FORM 2 if your child will be taking any medication while at camp.
- 4) After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by May 1st.

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) can not be reached:

Name(s): _____ Relationship to Camper: _____ Preferred Phones: (_____) (_____) _____

Allergies: No known allergies.

This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe on page 4 of this for 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.)

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 card 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 the physician 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 of 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 Name: _____
 Last Middle First
 Male Female Birth Date _____

Immunization History: Provide the month and year for each immunization. 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 influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) <input type="checkbox"/> Had chicken pox Date: _____						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) test Date: _____ <input type="checkbox"/> Negative <input type="checkbox"/> Positive						
H1N1						

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 of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

Medication: This camper will not take any daily medications while attending camp.
 This camper will take daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health.

The State of New Hampshire **requires 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.**

The "Medication Permission Form" is located on the back of the doctors portion of the health form(s) FORM 2

NO medication will be administered without the Medication Permission Form being completed by the parent and physician.

According to NH State Law, we are only able to administer nutritional supplements / homeopathic remedies with a physician's order and signature and documentation of a nutritional deficit.

The following are the ONLY non-prescription Medications stocked in the Birchmont Infirmary and are used on an as needed basis to manage illness and injury.

IF your child needs any over the counter medication not listed, please send the medication in a properly labeled bottle with the proper documentation.

Parent: Cross out those items the camper should NOT be given. AND Please initial here _____

Acetaminophen (Tylenol)
 Ibuprofen (Advil, Motrin)
 Robitussin, Robitussin DM, Delsym
 Phenylephrine HCl(Sudafed PE)
 Pseudoephedrine HCl (Sudafed)
 Claritan
 Diphenhydramine (Benadryl)
 Bactine
 Calamine Lotion
 Hydrocortisone 1% cream

Benadryl Cream or spray
 Gold Bond Powder
 Lotrimin Ultra
 Lamisil
 Athletes Foot Spray
 Orajel
 Campophenique
 Meclizine (12 and older)
 Dramamine
 Lice shampoo (RID or generic equivalent)

Generic cough drops
 Chloraseptic (Sore throat spray)
 Tums
 Maalox
 Bacitracin
 Topical antibiotic cream
 Aloe
 Aloe Grande Ointment
 Mineral Ice
 Saline Nasal Spray

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Camper Name: _____
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 Male Female Birth Date _____

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

- | | | | |
|--|--|--|--|
| 1. Ever been hospitalized?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had fainting or dizziness?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

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

Has the camper:

- Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? Yes No
- Ever been treated for emotional or behavioral difficulties or an eating disorder?..... Yes No
- During the past 12 months, seen a professional to address mental/emotional health concerns?..... Yes No
- 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 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.**

