

# CAMPER HEALTH HISTORY FORM 1

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

Dates will attend camp: from \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Camper Name: \_\_\_\_\_  
First Middle Last

Gender: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
Month/Day/Year

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: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Home: \_\_\_\_\_  
Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Home: \_\_\_\_\_

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Home: \_\_\_\_\_

**Allergies:** This camper is allergic to: \_\_\_\_\_  
*(Please describe below what the camper is allergic to and the reaction seen.)*

**Diet, Nutrition:** \_\_\_\_\_  
*(Please describe below.)*

**Restrictions:** \_\_\_\_\_  
*(Please describe below.)*

## **Medical Insurance Information:**

This camper is covered by family medical/hospital insurance: \_\_\_\_\_

**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 \_\_\_\_\_ 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.*

# 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 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 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 (PCV)		
Hepatitis B		
Hepatitis A		
Varicella (chicken pox) Had chicken pox Date:		
Meningococcal meningitis (MCV4)		

Tuberculosis (TB) test	Date: _____	Result: _____
------------------------	-------------	---------------

**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:

"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

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. **List those the camper should not be given:**

# 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? .....                   | 11. Had fainting or dizziness? .....                         |
| 2. Ever had surgery? .....                         | 12. Passed out/had chest pain during exercise? .....         |
| 3. Have recurrent/chronic illnesses? .....         | 13. Had mononucleosis ("mono") during the past 12 months?... |
| 4. Had a recent infectious disease? .....          | 14. If female, have problems with periods/menstruation?..... |
| 5. Had a recent injury? .....                      | 15. Have problems with falling asleep/sleepwalking? .....    |
| 6. Had asthma/wheezing/shortness of breath?.....   | 16. Ever had back/joint problems?.....                       |
| 7. Have diabetes? .....                            | 17. Have a history of bedwetting?.....                       |
| 8. Had seizures? .....                             | 18. Have problems with diarrhea/constipation?.....           |
| 9. Had headaches? .....                            | 19. Have any skin problems?.....                             |
| 10. Wear glasses, contacts, or protective eyewear? | 20. Traveled outside the country in the past 9 months?.....  |

**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:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? .....
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....
3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....
4. Had a significant life event that continues to affect the camper's life?.....  
(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.**

**Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.**

# 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

## Individual Health Record (For Camp Use Only)

**Initial Screening**

**Date/Time:** \_\_\_\_\_

**Initials:** \_\_\_\_\_

**Screening** has been conducted according to camp protocol and significant findings noted as follows:

- A. Any signs/symptoms of illness or injury upon arrival?..... No Yes as noted below
- B. History of exposure to communicable disease?..... No Yes as noted below
- C. Additions or corrections to information on this health history?..... No Yes as noted below
- D. Medication given to health-care staff?..... No Yes as noted below
- E. Any signs/symptoms of head lice?..... No Yes as noted below

**Provider notes: (date/time/initial all entries)** \_\_\_\_\_

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

**Exit Note:** Check one of the following:

Left camp this day with no reported illness or injury symptoms.

Left camp this day with the following problem/concern:

---

---

This person was told about the problem and instructed about follow-up as noted above: \_\_\_\_\_

Date/Time: \_\_\_\_\_ Initials: \_\_\_\_\_