Health History and Information Form 2024

Camp Name_____

Date of Camp_____

The following information must be completed by the parent/guardian, adult camper, or staff member. This will provide camp health care staff with information for providing appropriate health care. Physicals are not required for participants, unless he/she is currently under the care of a physician for an existing health issue. Please complete all pages as completely as possible and bring to camp on the day of registration. If you have any questions while filling out the form call the camp office at (419) 846-3010.

Personal Information

A) Camper Name _____ Birth Date _____ □ Male □ Female
Last First Middle Gender

Address _____
Street Address/ P O Box City State Zip

B) Parent/Guardian _____ Preferred Phone Number _____
□ Home Phone □ Work Phone □ Cell Phone

Address _____
Street Address/ P O Box City State Zip

Business Address_____ Business Phone _____

C) Additional Contact Person _____ Preferred Phone Number _____

Relationship _____ □ Home Phone □ Work Phone □ Cell Phone

Address _____
Street Address/ P O Box City State Zip

Business Address_____ Business Phone _____

D) In an emergency, if persons listed in A, B, and C are not available, notify:

Name _____ Relationship _____ Phone _____

Address _____
Street Address/ P O Box City State Zip

Insurance Information

Primary health and accident insurance coverage is through the participant's family. Secondary health and accident insurance coverage is through Inspiration Hills.

- Is the participant covered by family medical/hospital insurance? □ Yes □ No
- If yes, indicate the insurance carrier or plan name and policy number _____
  Group #/Policy# _____
- It is requested that a copy of the insurance card be provided for accuracy.

Important – The information in this box must be completed for participation

Parent/Guardian Authorization: The personal information and following health history is correct and complete as far as I know. The person described has my permission to engage in all camp activities as noted.

I give permission to the camp to provide routine 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 to the camp to arrange necessary related transportation for me/my child.

In the event that I cannot be reached in an emergency, I give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper or staff _____

Printed Name _____ Date_____

The following information must be completed by the parent/guardian, adult camper, or staff member. You are encouraged to be as complete as possible so that the camp can be aware of the camper's needs. Any changes in the information provided on this form should be provided to the camp health care staff upon the participant's arrival at camp. Keep a copy of this form for your records.

Health History and Information

Camper Name _____

A) ALLERGIES

□ the participant has no known allergies.

□ the participant is allergic to this medication/s:

Medication allergies	This causes anaphylaxis?	Describe reaction and management of the reaction
_____	□ Yes □ No	_____
_____	□ Yes □ No	_____
_____	□ Yes □ No	_____
_____	□ Yes □ No	_____

□ the participant has the following food allergies:

Food Allergies (list)

_____ This causes anaphylaxis? □ Yes □ No

Describe what happens when this food is eaten and how the reaction is managed.

_____

_____

_____ This causes anaphylaxis? □ Yes □ No

Describe what happens when this food is eaten and how the reaction is managed.

_____

_____

_____This causes anaphylaxis? □ Yes □ No

Describe what happens when this food is eaten and how the reaction is managed.

_____

_____

□ the participant has the following allergies not noted above:

Other Allergies – include insect bites, stings, hay fever, etc.

_____This causes anaphylaxis? □ Yes □ No

Describe the reaction and how the reaction is managed.

_____

_____

_____This causes anaphylaxis? □ Yes □ No

Describe the reaction and how the reaction is managed.

_____

_____

_____This causes anaphylaxis? □ Yes □ No

Describe the reaction and how the reaction is managed.

_____

_____

B) NUTRITION We can work effectively with some medically prescribed diets, but it may be necessary in some situations for the participant to bring special foods for certain diets.

□ the participant eats a regular, varied diet.

□ the participant is a vegetarian of this type: □ Semi-Vegetarian (no red meats) □ Vegan (no meats, eggs, or dairy) □ Pesco (no pork, beef, or chicken) □ Lacto-ovo (no beef, pork, chicken, seafood, or fish)

□ the participant is lactose intolerant

□ the participant responds with an anaphylactic reaction when this food is eaten: _____

□ the participant is on the following medically prescribed diet: _____

_____

_____

Camper Name _____

C) CHRONIC CONCERNS: Check all items that pertain to the participant and provide information about supportive health care.

□ Participant has no chronic health concerns.

□ Participant has the following chronic health concerns:

□ Asthma □ Headaches/Migraines □ Sleep Problem □ Diabetes

□ Difficult breathing □ Fainting □ Surgery history □ Seizure Disorder

□ Back Pain or Injury □ Knee or ankle weakness □ Other:_____

Provide information about supportive healthcare needed for each checked item:_____

_____

_____

_____

D) IMMUNIZATION HISTORY Provide the month and year for immunizations. Starred (*) items must be current.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4
DTP: Diphtheria, Tetanus, Pertussis				
*TD: Tetanus Booster	Must be current within past ten years.			
*IVP/OPV: Polio				
*MMR: Measles, Mumps, Rubella				
Hep B: Hepatitis B				
Hib: H Influenza, Type b				
Covid-19				

E) MEDICATIONS

Please list ALL medications (including over-the-counter or non-prescription drugs and vitamins) being taken routinely. Bring enough medication to last the entire time at camp. Prescriptions meds MUST be in the pharmacy containers with appropriate labels. All other remedies must be in the original container.

□ The participant takes NO medication on a routine basis.

□ The participant takes routine medication (including vitamins) as follows (attach more information as necessary):

Med # 1_____ Dosage_____ Specific times taken each day_____

_____

Med # 2_____ Dosage_____ Specific times taken each day_____

_____

Med # 3_____ Dosage_____ Specific times taken each day_____

_____

Med # 4_____ Dosage_____ Specific times taken each day_____

_____

Identify any medications taken during the school year that the participant does/may not take during the summer.

_____

_____

Note: The dosing schedules for some medications may be based on a daily school schedule. It is therefore recommended that a consultation be held with the prescribing physician to determine if the current dosing schedule is appropriate for the daily camp schedule. A typical daily schedule can be supplied, if needed.

To be completed only if participant is under the care of a physician for an existing ailment or condition

The applicant is under the care of a physician for the following:_____

_____

_____

In my opinion, the above participant 9 is 9 is not able to participate in an active camp program.

_____ _____

Signature of Medical Personnel Date

Camper Name _____

F) GENERAL PHYSICAL HISTORY

Has/does the participant	YES	NO
1. Had any recent injury, illness or infectious disease?	□	□
Have a chronic or recurring illness/condition?	□	□
2. Ever been hospitalized?	□	□
Ever had surgery?	□	□
3. Have frequent headaches?	□	□
Ever had a head injury?	□	□
Ever been knocked unconscious?	□	□
4. Wear glasses, <u>contacts</u>, or protective eyewear?	□	□
5. Ever passed out during or after exercise?	□	□
Ever been dizzy during or after exercise?	□	□
Ever had a seizure?	□	□
Ever had chest pain during or after exercise?	□	□
Ever had high blood pressure?	□	□
Ever been diagnosed with a heart murmur?	□	□

	YES	NO
6. Ever had a stinger, burner, or pinched nerve?	□	□
Ever had heat or muscle cramps?	□	□
7. Ever had back problems?	□	□
Ever had problems with arm or leg joints?	□	□
Have an orthodontic appliance being bought to camp?	□	□
8. Have any skin problems?	□	□
9. Have any problems with teeth?	□	□
10. Had chicken pox or immunized for chicken pox?	□	□
Had mononucleosis in the past 12 month?	□	□
Had problems with diarrhea/constipation?	□	□
11. Have problems with sleepwalking?	□	□
12. If female, have begun menstruation?	□	□
If female, have an abnormal menstrual history?	□	□

Please explain any "yes" answers, noting the question number.

_____
_____
_____
_____

Does the participant have any piercings? □ Yes □ No

If so, where? □ Ears □ Eyebrow □ Nose □ Tongue □ Belly Button

□ Other_____

Has the participant been in countries other than the United States in the past nine months? □ Yes □ No

Country:_____Dates_____

Country:_____Dates_____

Country:_____Dates_____

G) MENTAL AND EMOTIONAL HEALTH

Has the participant been diagnosed with attention deficit disorder (ADD) or (AD/HD)?	□ Yes	□ No
Has the participant been diagnosed with depression, OCD, panic/anxiety disorder?	□ Yes	□ No
Does the participant have an eating disorder? Type_____	□ Yes	□ No
Does the participant have an emotional health concern?	□ Yes	□ No
Have there been any changes in the participant's mental health in the past month?	□ Yes	□ No

Explain_____

_____

Use this space to provide additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware (recent divorce issues, deaths in family or friends, or other trauma).

_____
_____
_____

Name of family physician_____**Phone ( )**_____

Address_____

Name of family dentist/orthodontist_____ **Phone ( )** _____

Address_____