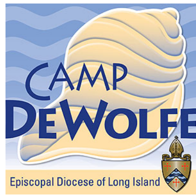


CAMP DeWOLFE

CAMPER HEALTH HISTORY FORM

To Parent(s)/Guardian(s): Please complete this health form and attach additional information if needed. Please ensure your child's health-care provider reviews the form and completes and signs their section on page 5. After completion, please sign the form and return it to Camp DeWolfe by June 1st

HEALTH HISTORY FORM

- Camper Full Name: ____
- Birth Date: ____________________Age at Camp: ___________ Gender: Male ___ Female ___
- Dates will attend camp from: __________________________ to __________________________________
- Home Address: ____
- Home Phone: ____
- Custodial Parent/guardian #1 (Name): ____
- Relationship to camper: __________________________ Cell Phone: _____________________________
- Place of Employment: ____________________________ Work Phone: ______________________________
- Custodial parent/guardian #2 (Name): ____
- Relationship to camper: __________________________ Cell Phone: ______________________________
- Place of Employment: ____________________________Work Phone: ______________________________
- If not the above are available in an emergency, notify: __________________________________
- Relationship: _____________________________________ Phone: __________________________________
- Address:____
- Name of family dentist: ___________________________Phone: ____________________________________
- Address: ____

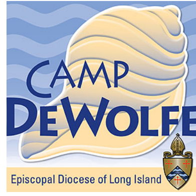
INSURANCE INFORMATION

- Is the participant covered by family medical/hospital insurance? YES___ NO
- If YES, indicate Insurance Company: ____
- Policy #: _______________________________ Subscriber ____
- Insurance Company Phone Number: ____

  (A photocopy of front & back of health insurance cards must be attached to this form)

ALLERGIES

___ No known allergies.
___ This camper is allergic to: (Please describe what the camper is allergic to and the reaction seen)
___ Medicine____
____
___ Food ____
____
___ The environment – include insect stings, hay fever, asthma, etc.___________________________
____



CAMP DeWOLFE
CAMPER HEALTH HISTORY FORM

MEDICATIONS

Please list ALL routine prescription and over-the-counter or non-prescription drugs (including vitamins). Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

Please check:
___ This person takes medications as follows OR ___ This person takes NO medications during camp

- Med # 1 ________________________ Dosage _____ Specific times taken each day __________________
- Reason for taking ____
- Med # 2 ________________________ Dosage _____ Specific times taken each day __________________
- Reason for taking ____
- Med # 3 ________________________ Dosage _____ Specific times taken each day __________________
- Reason for taking ____
- *Please attach additional pages for more medications.*
- Identify any medications taking during the school year that participant does not take during summer ____

AUTHORIZATION FOR STOCK NON-PRESCRIPTION DRUG ADMINISTRATION BY CAMP HEALTH CARE PROVIDER

There may be times at camp when your child will ask for non-prescription medications/treatments to help relieve symptoms related to minor conditions such as poison ivy, headache or upset stomach etc. A Registered Nurse (RN) or Licensed Practical Nurse (LPN) is always available at the Health Center to assist in the assessment of the camper's conditions and to respond appropriately in dispensing these medications/treatments.

The **PARENT/GUARDIAN** must indicate which of the available non-prescription drugs/ treatments **MAY NOT** be used or given by checking the appropriate boxes on the enclosed list. The Camp DeWolfe physician has approved the non-prescription drugs/treatments listed below for use at camp and we will have these in stock in our Health Center:

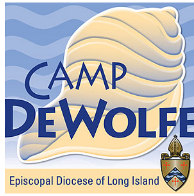
NON PRESCRIPTION TOPICAL MEDICATIONS

( ) denotes use for item
[ ] denotes active ingredient

Check only if NOT to be given:

___ Alcohol Prep. Pads (wound cleaning)
___ Aloe Vera Gel (moisturizing therapy)
___ Ammonia Inhalants (fainting)
___ Anti-fungal powder/spray or cream [Tinactin or similar]
___ Anti-microbial wipes (wound cleaning)
___ Anti-biotic Ointment / Bacitracin (wound cleaning)
___ Betadine Solution (topical antiseptic)
___ Calagel / Caladryl / Calamine Lotion (skin irritation relief)
___ Foille Medicated First Aid Spray (sunburn / minor burn relief)
___ Hydrocortisone Cream 1% (skin irritations)
___ Hydrogen Peroxide 3% (wound cleaning)
___ Ice Packs
___ Mediosine Sting Ease Swabs
___ Medicated Powder (skin irritations)
___ Off Skintastic (insect repellent)
___ Petroleum Jelly / Vaseline (chapped lips)
___ PhisoDerm (skin cleaner)
___ Saline Eye Drops (eye irritations)
___ Skin So Soft Bug Gard (insect repellent)
___ No-Ad Sun Block SPF 30 (sunscreen)
___ No-Ad Sun Block SPF 45 (sunscreen)
___ Solarepel Sunscreen Spray SPF 25
___ Silvadene Cream (burn relief)
___ Swimmer's Ear Drops (or ½ alcohol ½ vinegar solution)
___ Tecnu Wash (Poison Ivy / Oak)
___ Viractin Gel (cold sore medication)
___ Witch Hazel (astringent)

Comments: ____
____



CAMP DeWOLFE

CAMPER HEALTH HISTORY FORM

NON PRESCRIPTION ORAL MEDICATIONS

( ) denotes use for item
[ ] denotes active ingredient

Check only if NOT to be given:

___ Anbesol Ointment (tooth pain/canker sores)
___ Acetaminophen Tablets 500 mg
___ Acetaminophen Tablets 325 mg
___ Acetaminophen Children's Chewable 80 mg
___ Anti-Diarrheal Tablets [Loperamide Hydrochloride 2 mg]
___ Bismuth Tablets (indigestion / diarrhea)
___ Benadryl Tablets 25 mg (bug bite/poison ivy reactions)
___ Benadryl Tablets 50 mg (bug bite/poison ivy reactions)
___ Benadryl Childrens Liquid (no alcohol) [Diphenhydramine HCL] (allergy relief)
___ Chloraseptic Throat Spray (sore throat relief)
___ Complete Allergy Medicine Tablets 25mg
___ Complete Allergy Medicine Tablets 50mg [Dipenhydramine HCL]
___ Chlor Trimeton 4-hour Antihistamine [Chlorpheniramine Maleate]
___ Cough Suppressant Drops-Cherry
___ Guaiatussin DM Liquid (non-alcohol) (cough suppressant)
___ Ibuprofen Tablets 200 mg (pain relief)
___ Pepto Bismol Tablet [bismuth subsalicylate]
___ Pepto Bismol Liquid [bismuth subsalicylate]
___ Pseudoval – Nasal Decongestant [Pseudoephedrine HCL 30mg]
___ Senna Tablets (natural laxative)
___ Sepasoothe Lozenge (anesthetic throat lozenge)
___ Tums (indigestion) [calcium carbonate]

Comments: ____
____

I give permission for a Registered Nurse, trained in accordance with the State of New York Health Department regulations and under the authorization of the Camp Physician through the 2012 Camp DeWolfe Standing Orders, to administer non-prescription medications, as indicated above, in accordance with the label directions and with attention to the relevant side effects also listed on the label of the above medications.

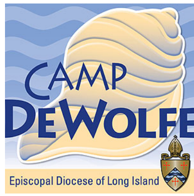
Signature of Parent/Guardian:__________________________________ **Date:** _______________

GENERAL QUESTIONS (Explain 'YES' answers below or on separate sheet)

Has/does the participant:	YES NO
Ever been hospitalized?	___ ___
Ever had surgery?	___ ___
Have recurrent/chronic illnesses?	___ ___
Had a recent infectious disease?	___ ___
Had a recent injury?	___ ___
Had asthma/shortness of breath?	___ ___
Have diabetes?	___ ___
Had seizures?	___ ___
Had headaches?	___ ___
Wear glasses, contact or protective eyewear?	___ ___
Had fainting or dizziness?	___ ___
Had frequent ear infections?	___ ___
Passed out/had chest pain?	___ ___

	YES NO
Had mononucleosis during the past 12 months?	___ ___
If female, have problems with periods?	___ ___
Have problems with falling asleep/sleepwalking?	___ ___
Ever had back/joint problems?	___ ___
Ever had high blood pressure?	___ ___
Have a history of bedwetting?	___ ___
Have problems with diarrhea or constipation?	___ ___
Have any skin problems?	___ ___
Traveled outside the country in the past 9 mths?	___ ___
Ever had an eating disorder?	___ ___
Ever had emotional difficulties and sought professional help?	___ ___
Ever been diagnosed with a heart murmur?	___ ___

Please explain any "YES" answers, noting the number of the questions: ______________________________
____
____
____
____



CAMP DeWOLFE
CAMPER HEALTH HISTORY FORM

PARENT/GUARDIAN AUTHORIZATIONS

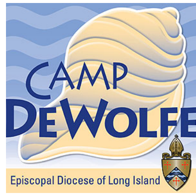
This health history is correct and complete to the best of my knowledge, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical 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 I cannot be reached in an emergency, I hereby 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.

Health Insurance Information… I understand that:

- The Camp DeWolfe staff will make every effort to insure that medical personnel are given my child's health insurance information at the time of treatment when I have provided copies of the necessary documents;
- Not all medical treatment facilities will file insurance claims. If this situation occurs with my child, Camp DeWolfe will forward the bills to me and I agree to pay them within 60 days of receipt;
- If Camp DeWolfe is required to obtain a prescription for my child, I agree to reimburse Camp DeWolfe for any co-payment or prescription expense incurred on my child's behalf;
- Camp DeWolfe will notify the day that my child is treated, provided that I have given correct contact information for myself and/or an additional emergency contact. Camp DeWolfe will follow-up with written notification to me, along with copies of all documents related to my child's treatment;
- If my child does not have health insurance, or I fail to provide Camp DeWolfe with the necessary documentation for coverage, I agree to pay all medical expenses, including prescriptions, incurred on behalf of my child.

Signature of Parent/Guardian/Staff Member: ____

Printed Name: ____ **Date:** ________________________



CAMP DeWOLFE

CAMPER HEALTH HISTORY FORM

TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Exam (must be within 24 months of attending) ______________________________

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken Pox)
- ☐ German Measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Rubella

TB Mantoux Test
Date of last test __________
Results: ☐ Positive ☐ Negative

Please give all dates of immunizations for:

Vaccine: Dates?	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	______	______	______	______	______
TD (Tetanus/Dipth)	______	______	______	______	______
Tetanus	______	______	______	______	______
Polio	______	______	______	______	______
MMR	______	______	______	______	______
Or Measles	______	______	______	______	______
Or Mumps	______	______	______	______	______
Or Rubella	______	______	______	______	______
Haemophilus Infl B	______	______	______	______	______
Hepatitis B	______	______	______	______	______
Varicella (chicken pox)	______	______	______	______	______

Height: ______________ Weight: ______________ B/P: ______________ Gross Dental: ________________

___ Camper may participate in all camp activities.
___ Camper may participate in all camp activities with the following restrictions, exceptions or modifications:
____
____
____

Name of family physician: ______________________________ Phone: ___________________________
Office Address:
____
____

I have reviewed the Camper Health History Form 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).

Signature of Health Care Provider: ____

Printed Name of Health Care Provider: ____

Please use a separate sheet to provide any additional information about the participant's behavior & physical, emotional, or mental health about which the camp should be aware.

CAMP DeWOLFE

Episcopal Diocese of Long Island

CAMP DeWOLFE
CAMPER HEALTH HISTORY FORM

FOR CAMP USE ONLY
HEALTH RECORD

Initial Screening: Date/Time: ______________________ Initials: ______________

___ Screening has been conducted according to camp protocol and significant findings noted as follows;

	No	Yes (note below)
1. Any signs/symptoms of illness or injury upon arrival?	___	___
2. History of exposure to communicable disease?	___	___
3. Additions or corrections to information on this health history?	___	___
4. Medications given to health-care staff?	___	___
5. Any signs/symptoms of head lice?	___	___

Provider notes: (date/time/initial all entries)

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Exit Note:

___ Left camp this day with no reported illnesses or injury symptoms

___ Left camp this day with the following problem/concern:

____
____
____

This person was told about the problem and instructed about follow-up noted above: ______________________

Date/Time: ________________ Initials: _________