

HEALTH HISTORY FORM FOR CAMP

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

2010

■ Session(s) attending:

TO BE COMPLETED BY PARENT/GUARDIAN/STAFF MEMBER:

■ First Name: _____ Middle: _____ Last: _____

● Home Address: _____

● Birth Date: _____ ● Age at Camp: _____ ● Sex: Male Female

● 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 available in an emergency, notify: _____

● Relationship: _____ Home Phone: () _____

● Address: _____

● Cell Phone: () _____ Work Phone: () _____

■ Name of family dentist: _____ Phone: () _____

● Address: _____

INSURANCE INFORMATION:

● Is the participant covered by family medical/hospital insurance? YES NO

● If YES, indicate carrier or plan name: _____

Group #: _____

Photocopy of front & back of health insurance card(s) must be attached to form.

ALLERGIES/RESTRICTIONS - List all known ■ Describe restriction and/or reaction and management of the reaction

Medication allergies (list)

Food allergies (list)

Other allergies (list) - include insect stings, asthma, etc.

■ **MEDICATIONS BEING TAKEN:** 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 NOTE: State regulations require a separate "Authorization For The Administration Of Medication From Home" form for all prescription or over-the-counter medications that campers bring to Camp. These forms must be signed by the prescribing doctor or physician's assistant.

<input type="checkbox"/> This person takes medications as follows:	OR	<input type="checkbox"/> This person takes NO medications on a routine basis.
● 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 _____		
○ Attach additional pages for more medications.		
● Identify any medications taking during the school year that participant does/may not take during the summer: _____		

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

	YES	NO		YES	NO
● Has/does the participant:					
1. Had any recent injury, illness or infectious disease	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			

● Please explain any "YES" answers, noting the number of the questions: _____

*****MUST BE SIGNED BY PARENT/GUARDIAN/STAFF MEMBER*****

■ 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 Washington 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 Washington will forward the bills to me and I agree to pay them within 60 days of receipt;
- If Camp Washington is required to obtain a prescription for my child, I agree to reimburse Camp Washington for any co-payment or prescription expense incurred on my child's behalf;
- Camp Washington 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 Washington 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 Washington 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: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER:

■ Date of Physical Exam: _____
(must be within 24 months of last day attending)

<p>■ Which of the following has the participant had?</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Chicken Pox</p> <p><input type="checkbox"/> German Measles</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Hepatitis A</p> <p><input type="checkbox"/> Hepatitis B</p> <p><input type="checkbox"/> Hepatitis C</p> <p>■ TB Mantoux Test Date of last test _____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative</p> <p>■ Height: _____ Weight: _____ B/P: _____ Gross Dental: _____</p> <p><input type="checkbox"/> Camper may participate in all camp activities. <input type="checkbox"/> Camper may participate in all camp activities with the following restrictions, exceptions or modifications: _____</p> <p>_____</p> <p>_____</p> <p>■ Name of family physician: _____ Phone: () _____</p> <p>● Address: _____</p>	<p>■ Please give all dates of immunization for:</p> <table border="0"> <thead> <tr> <th>Vaccine:</th> <th>Dates?</th> <th>Mo/Yr</th> <th>Mo/Yr</th> <th>Mo/Yr</th> <th>Mo/Yr</th> <th>Mo/Yr</th> <th>Mo/Yr</th> </tr> </thead> <tbody> <tr> <td>DTP</td> <td></td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>TD (tetanus/diphtheria)</td> <td></td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Tetanus</td> <td></td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Polio</td> <td></td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>MMR</td> <td></td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>or Measles</td> <td></td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>or Mumps</td> <td></td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>or Rubella</td> <td></td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Haemophilus Influenza B</td> <td></td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Hepatitis B</td> <td></td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Varicella (chicken pox)</td> <td></td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Vaccine:	Dates?	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	DTP		_____	_____	_____	_____	_____	_____	TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____	Tetanus		_____	_____	_____	_____	_____	_____	Polio		_____	_____	_____	_____	_____	_____	MMR		_____	_____	_____	_____	_____	_____	or Measles		_____	_____	_____	_____	_____	_____	or Mumps		_____	_____	_____	_____	_____	_____	or Rubella		_____	_____	_____	_____	_____	_____	Haemophilus Influenza B		_____	_____	_____	_____	_____	_____	Hepatitis B		_____	_____	_____	_____	_____	_____	Varicella (chicken pox)		_____	_____	_____	_____	_____	_____	<p>⊕ 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.</p>
Vaccine:	Dates?	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr																																																																																											
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*****MUST BE SIGNED BY HEALTHCARE PROVIDER*****

<p>■ Signature of Health Care Provider:</p> <p>_____</p>	<p>■ Printed Name of Health Care Provider:</p> <p>_____</p>
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To be completed and signed by Parent/Guardian/Staff Member:



**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/STAFF MEMBER** 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 Washington 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:

() denotes use for item
[] denotes active ingredient

NON PRESCRIPTION TOPICAL MEDICATIONS

**Check box
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 1/2 alcohol 1/2 vinegar solution)
- Tecnu Wash (Poison Ivy / Oak)
- Viractin Gel (cold sore medication)
- Witch Hazel (astringent)

Comments:

() denotes use for item
[] denotes active ingredient

NON PRESCRIPTION ORAL MEDICATIONS

Check box 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 (non 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:

*****MUST BE SIGNED by Parent/Guardian/Staff Member*****

■ I give permission for a Registered Nurse, trained in accordance with the State of Connecticut Health Department regulations and under the authorization of the Camp Physician through the 2010 Camp Washington 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/Staff Member:

_____ Date: _____



Camp Washington

190 Kenyon Rd.
Lakeside, CT 06758
(860) 567-9623

www.campwashington.org
camp@campwashington.org

2010

HOME INFORMATION FORM

PLEASE NOTE: Each camper will be given an opportunity to tell us what he or she expects at camp this summer. This form is to be completed by the **PARENTS**. This information is **confidential**. Please complete and return form to the Camp Office.

☉ Sex: Male Female

☉ Session(s) attending - name & date:

1. _____

2. _____

☉ Home Address: _____

State: _____ Zip: _____

☉ Phone #'s
(H) _____

(W) _____

Cell: _____

☉ Birth Date: _____ (Month /Date/Year)

☉ Age in Camp: _____

☉ Birthday while in Camp: YES NO

☉ In case of divorce or separation, with whom does the child live?

☉ In case of divorce or separation are there any parental restrictions we should be informed of?
 YES NO

If yes, please attach a copy of your custody agreement.

☉ Number & ages of brothers & sisters:

☉ Denomination: Episcopal Catholic
 Lutheran Congregational
 Methodist Baptist Unaffiliated
 Other _____

Parish Name: _____

Parish Town: _____

☉ Does child regularly attend:
(check all that apply)

Services Youth Group
 Sunday School Choir
 Acolyte Other: _____

☉ Is this child's first year at Camp Washington?
 YES NO

☉ If yes, how did you hear about our program?
 Parish "Good News" newspaper
 Friend Internet
 American Camp Association
 Other: _____

☉ Has child attended other camps?
 YES NO
If yes, list name(s) & year(s)

Camp Name Year Day/Resident

- ⊙ How does your child feel about coming to Camp Washington this summer?

- ⊙ If your child was at Camp Washington last summer, please mention anything that stands out in your mind (positive or negative) of that experience that will enable your child's counselor to repeat or improve the experience this year.

- ⊙ Has child ever had any problem with homesickness? YES NO
If yes, please explain:

- ⊙ Does child have any problem with bed wetting? YES NO
If yes, please explain:

- ⊙ Are there any restrictions on the child's activities? YES NO
If yes, please explain:

- ⊙ Is your child on continuing medication? YES NO If yes, please explain:

- ⊙ What skills would you like your child to develop at camp? What would you like most for him or her to get out of the camp experience?

- ⊙ Does your child have any special needs (behavioral, emotional, physical, dietary) that might affect his or her experience at camp? If so, what treatment has he or she been receiving and from what source? **** (Our experience is the more we know the better able we are to help create a positive experience for the camper)****

- ⊙ Is there any other information not included on this form that your child's counselor should have to better enable them to provide for a positive camp experience?

PLEASE FEEL FREE TO USE ADDITIONAL SHEETS OF PAPER IF NECESSARY TO ADEQUATELY ANSWER ANY OF THE QUESTIONS!

⊛ By signing this form PARENT & CAMPER... ⊛

- Are giving permission to participate in all camp activities.
- Understand that any activity involving any nicotine products, alcohol, illegal drugs or sexual activity are not acceptable at camp. Campers involved in such activities will be sent home immediately.
- Understand that camp is a safe environment for everyone. Inappropriate behaviors that are unhealthy for the camp community (i.e. bullying, violence, vandalism, destruction) will be considered cause for dismissal on a case-by-case basis and in conjunction with parent discussion.
- Are giving permission for my child to participate in any field trips from camp which may occur during his/her stay at camp. I understand that all trips from camp will be led by responsible, qualified camp staff following the guidelines set by the State of Connecticut and the American Camp Association.
- Are giving permission for Camp Washington to send periodic electronic newsletters to the e-mail addresses listed on the registration form.
- Are giving permission for photographs and video footage of my child taken during camp to be used in promotional displays, videos, brochures, camp web site, & newsletters etc.

● **Parent / Guardian Signature:**

● **Parent / Guardian Name (please print):**

● **Date Signed:**

● **Camper Signature:**
