

HEALTH HISTORY FORM FOR CAMP

The information on this form is not part of the camper 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.

2026

■ Session(s) attending:

TO BE COMPLETED BY PARENT/GUARDIAN:

■ First: _____ Middle: _____ Last: _____

● Home Address: _____

● Birth Date: _____ ● Age at Camp: _____ ● Home Phone # () _____

● Gender: Male Female Genderqueer/Non-Binary Fill In The Blank: _____

■ 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 camper 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. They **MUST** be 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.

This person takes medications as follows: OR 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:

PLEASE NOTE: State regulations require a separate **“Authorization For The Administration Of Medication From Home”** form (FOUND ON OUR WEBSITE) for each prescription or over-the-counter medication that campers bring to Camp. These forms must be signed by both the prescribing doctor or physician’s assistant and Parent/Guardian.

ABSOLUTELY NO MEDICATIONS WILL BE GIVEN WITHOUT THESE SIGNED FORMS ON FILE AT CAMP!

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

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

- A. The Camp Washington staff will make every effort to ensure that medical personnel are given my camper's health insurance information at the time of treatment when I have provided copies of the necessary documents;
- B. Not all medical treatment facilities will file insurance claims. If this situation occurs with my camper, Camp Washington will forward the bills to me and I agree to pay them within 60 days of receipt;
- C. If Camp Washington is required to obtain a prescription for my camper, I agree to reimburse Camp Washington for any co-payment or prescription expense incurred on my child's behalf;
- D. Camp Washington will notify the day that my camper 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 camper's treatment;
- E. If my camper 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 camper.

● Signature of Parent/Guardian: _____

● Printed Name: _____ Date: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER:

■ Date of Physical Exam: _____
 (Physical Exams Are Valid For 3 Years From Date Of Last Exam)

■ This camper is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles	___	___	Hepatitis B	___	___
Mumps	___	___	Diphtheria	___	___
Rubella	___	___	Pertussis	___	___
Chickenpox	___	___	Pneumococcal conjugate	___	___
Tetanus (mo/yr) _____	___	___	Polio	___	___

✳ 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.

Comments: _____

■ 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: () _____

● Address: _____ City: _____ State: _____

*****MUST BE SIGNED BY HEALTHCARE PROVIDER*****

■ Signature of Health Care Provider: _____

■ Date: _____

■ Printed Name of Health Care Provider: _____

To be completed and signed by Parent/Guardian:



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 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:

NON PRESCRIPTION ORAL /TOPICAL MEDICATIONS

Check box only if **NOT** to be given

() denotes use for item
[] denotes active ingredient

- Acetaminophen Tablets
- 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)
- Benadryl (bug bite/poison ivy reactions)
- Betadine Solution (topical antiseptic)
- Blistex
- Calagel / Caladryl / Calamine Lotion (skin irritation relief)
- Hydrocortisone Cream 1% (skin irritations)
- Hydrogen Peroxide 3% (wound cleaning)
- Ibuprofen Tablets (pain relief)
- Medicated First Aid Spray (sunburn / minor burn relief)
- Mediosine Sting Ease Swabs

- Milk of Magnesia
- Petroleum Jelly / Vaseline (chapped lips)
- Saline Eye Drops (eye irritations)
- Swimmer's Ear Drops [or ½ alcohol ½ vinegar solution]
- Tecnu Wash (Poison Ivy/Oak)
- Tums (indigestion) [calcium carbonate]
- Visine
- Visine AC
- Witch Hazel (astringent)

Comments:

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

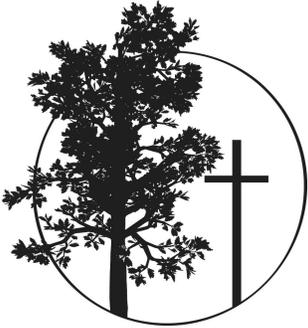
■ I give permission for a Registered Nurse, trained in accordance with the State of Connecticut Health Department regulations and under the authorization of the Camp Physician through the Camp Washington Standing Orders, to administer non-prescription medications, as indicated above, in accordance with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

■ Signature of Parent/Guardian: _____ Date: _____

Camp Washington

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

www.campwashington.org



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 PARENT/GUARDIAN. This information is **confidential**.

⊙ Gender: Male Female Genderqueer/Non-Binary Fill In The Blank: _____

⊙ Session(s) attending - name & date:

1. _____

2. _____

⊙ 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:

- Baptist
- Catholic
- Christian
- Congregational
- Episcopal
- Jewish
- Lutheran
- Methodist
- Muslim
- Unaffiliated
- Other _____

⊙ Does the camper regularly attend:
(check all that apply)

- Services
- Youth Group
- Sunday School
- Choir
- Acolyte
- Other: _____

⊙ Is this the campers 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 the camper attended other camps?
 YES NO

If yes, list name(s) & year(s)

<u>Camp Name</u>	<u>Year</u>	<u>Day/Resident</u>
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⊙ How does the camper feel about coming to Camp Washington this summer?

⊙ If the camper was at Camp Washington in the past, 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 the camper ever had any problem with homesickness?

YES NO

If yes, please explain:

☉ Does the camper have any problem with bed wetting?

YES NO

If yes, please explain:

☉ Are there any restrictions on the camper's activities?

YES NO

If yes, please explain:

☉ Is the camper on continuing medication?

YES NO

If yes, please explain:

☉ What skills would you like the camper to develop at camp? What would you like most for him or her to get out of the camp experience?

☉ Does the camper 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 the camper'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, cannabis, illegal drugs or sexual activity are not acceptable at camp. Campers involved in such activities will be sent home immediately. Camp Washington reserves the right to search any camper's belongings at any time.
- 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.
- Are giving permission for the camper 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: