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.

2020

■ Session(s) attending:

_____

_____

TO BE COMPLETED BY PARENT/GUARDIAN/STAFF MEMBER:

■ Last Name: _____ Middle: _____ First: _____

- Home Address: _____
- Birth Date: _____ ● Age at Camp: _____ ● Gender: ☐ Male ☐ Female ☐ Other: _____
- 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.

_____

_____

 Camper's Name: _____

■ **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)**

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

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

_____

_____

 Camper's Name: _____

*****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:**

A. The Camp Washington staff will make every effort to ensure 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;
B. 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;
C. 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;
D. 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;
E. 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:** _____
(Physical Exams Are Valid For 3 Years From Date Of Last Exam)

■ This camper/staff 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:**
_____

 Camper's Name: _____

To be completed and signed by Parent/Guardian/Staff Member:

2020

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:

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/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 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: _____

 Camper's Name: _____

Camp Washington

190 Kenyon Rd.
Lakeside, CT 06758
(860) 567-9623
www.campwashington.org
camp@campwashington.org

2020

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.

◎ Gender: _____

◎ 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:

☐ Baptist ☐ Catholic ☐ Christian
☐ Congregational ☐ Episcopal ☐ Jewish
☐ Lutheran ☐ Methodist ☐ Muslim
☐ Unaffiliated

☐ Other _____

◎ 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?

 Camper's Name: _____

◎ 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. 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 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:**

_____