

# HEALTH HISTORY FORM FOR CAMP

# 2024

The information on this form 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.

Session(s) attending:

Family Camp-  
Adult

## TO BE COMPLETED BY ADULT ATTENDEE:

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Home Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Home Phone # ( ) \_\_\_\_\_

Gender:  Male  Female  Genderqueer/Non-Binary  Fill In The Blank: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

### INSURANCE INFORMATION:

Is the Attendee 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.

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

Has/does the Attendee:	YES	NO		YES	NO
1. Had any recent injury, illness or infectious disease	<input type="checkbox"/>	<input type="checkbox"/>	15. Have any skin problems (e.g. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	16. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>			
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>			
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>			
8. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>			
9. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
10. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
11. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>			
12. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
13. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
14. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "YES" answers, noting the number of the questions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

■ HEALTH EXAM/RECORD

Physical Exams Are Valid For 3 Years From Date of Last Examination

**TO BE COMPLETED BY HEALTH CARE PROVIDER:**

Date of Exam \_\_\_\_/\_\_\_\_/\_\_\_\_

May participate in all camp activities: YES NO

May participate except for: \_\_\_\_\_

Does the individual have any known medical or emotional illness or disorder that poses a risk to others or which affects the individual's functional ability to participate safely in a youth camp? YES NO

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Are there any prescription or over the counter medication(s) this individual needs to take while at camp? YES NO

If yes, indicate names of medication(s): \_\_\_\_\_

Does the individual have any disabilities or special health care needs such as allergies, special dietary needs? YES NO

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Additional Comments:

\_\_\_\_\_  
\_\_\_\_\_

Printed Name of Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Physician, PA, APRN or RN \_\_\_\_\_ Date Form Signed: \_\_\_\_\_

**NON PRESCRIPTION ORAL /TOPICAL MEDICATIONS**

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

There may be times at camp when you 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 your conditions and to respond appropriately in dispensing these medications/treatments. 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:

Please indicate which of the available non-prescription drugs/ treatments MAY NOT be used or given by checking the appropriate boxes on the enclosed list.

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 Adult Attendee\*\***

■ 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 Adult Attendee: \_\_\_\_\_ Date: \_\_\_\_\_

By signing this form, Adult Attendee...

- Is giving permission to participate in all camp activities.
- Understands that any activity involving any nicotine products, alcohol, cannabis, illegal drugs, or sexual activity are not acceptable at camp. Anyone involved in such activities will be sent home immediately. Camp Washington reserves the right to search any belongings at any time.
- Understands 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.
- Is giving permission for Camp Washington to send periodic electronic newsletters to the e-mail addresses listed on the registration form.
- Is giving permission for photographs and video footage taken during camp to be used in promotional displays, videos, brochures, camp web site, & newsletters etc.

■ Signature of Adult Attendee: \_\_\_\_\_ Date: \_\_\_\_\_