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._____
_____

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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: _____
_____

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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 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		YES NO
Ever been hospitalized?	__ __	Had mononucleosis during the past 12 months?	__ __
Ever had surgery?	__ __	If female, have problems with periods?	__ __
Have recurrent/chronic illnesses?	__ __	Have problems with falling asleep/sleepwalking?	__ __
Had a recent infectious disease?	__ __	Ever had back/joint problems?	__ __
Had a recent injury?	__ __	Ever had high blood pressure?	__ __
Had asthma/shortness of breath?	__ __	Have a history of bedwetting?	__ __
Have diabetes?	__ __	Have problems with diarrhea or constipation?	__ __
Had seizures?	__ __	Have any skin problems?	__ __
Had headaches?	__ __	Traveled outside the country in the past 9 mths?	__ __
Wear glasses, contact or protective eyewear?	__ __	Ever had an eating disorder?	__ __
Had fainting or dizziness?	__ __	Ever had emotional difficulties	
Had frequent ear infections?	__ __	and sought professional help?	__ __
Passed out/had chest pain?	__ __	Ever been diagnosed with a heart murmur?	__ __

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

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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: _____

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TO BE COMPLETED BY HEALTH CARE PROVIDER

Name of Camper: _____

Date of Physical Exam (must be within 12 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.