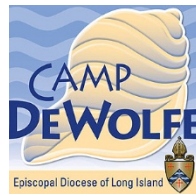




CAMP DeWOLFE CAMPER HEALTH HISTORY FORM



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

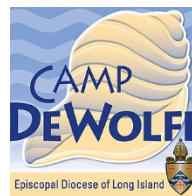
- Is the participant covered by family medical/hospital insurance? YES__ NO __
 - If YES, indicate Insurance Company: _____
 - Policy #: _____ Subscriber _____
 - Insurance Company Phone Number: _____
- (A photocopy of front & back of health insurance cards must be attached to this form)**

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. _____



CAMP DeWOLFE CAMPER HEALTH HISTORY FORM



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

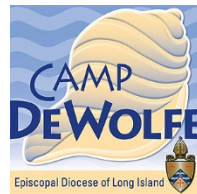
Check only if NOT to be given:

- | | |
|---|---|
| <input type="checkbox"/> Alcohol Prep. Pads (wound cleaning)
<input type="checkbox"/> Aloe Vera Gel (moisturizing therapy)
<input type="checkbox"/> Ammonia Inhalants (fainting)
<input type="checkbox"/> Anti-fungal powder/spray or cream [Tinactin or similar]
<input type="checkbox"/> Anti-microbial wipes (wound cleaning)
<input type="checkbox"/> Anti-biotic Ointment / Bacitracin (wound cleaning)
<input type="checkbox"/> Betadine Solution (topical antiseptic)
<input type="checkbox"/> Calagel / Caladryl / Calamine Lotion (skin irritation relief)
<input type="checkbox"/> Foille Medicated First Aid Spray (sunburn / minor burn relief)
<input type="checkbox"/> Hydrocortisone Cream 1% (skin irritations)
<input type="checkbox"/> Hydrogen Peroxide 3% (wound cleaning)
<input type="checkbox"/> Ice Packs
<input type="checkbox"/> Mediosine Sting Ease Swabs | <input type="checkbox"/> Medicated Powder (skin irritations)
<input type="checkbox"/> Off Skintastic (insect repellent)
<input type="checkbox"/> Petroleum Jelly / Vaseline (chapped lips)
<input type="checkbox"/> PhisoDerm (skin cleaner)
<input type="checkbox"/> Saline Eye Drops (eye irritations)
<input type="checkbox"/> Skin So Soft Bug Gard (insect repellent)
<input type="checkbox"/> No-Ad Sun Block SPF 30 (sunscreen)
<input type="checkbox"/> No-Ad Sun Block SPF 45 (sunscreen)
<input type="checkbox"/> Solarepel Sunscreen Spray SPF 25
<input type="checkbox"/> Silvadene Cream (burn relief)
<input type="checkbox"/> Swimmer's Ear Drops (or ½ alcohol ½ vinegar solution)
<input type="checkbox"/> Tecnu Wash (Poison Ivy / Oak)
<input type="checkbox"/> Viractin Gel (cold sore medication)
<input type="checkbox"/> Witch Hazel (astringent) |
|---|---|

Comments: _____



CAMP DeWOLFE CAMPER HEALTH HISTORY FORM



NON PRESCRIPTION ORAL MEDICATIONS

() denotes use for item
[] denotes active ingredient

Check only if NOT to be given:

- | | |
|---|---|
| <input type="checkbox"/> Anbesol Ointment (tooth pain/canker sores) | <input type="checkbox"/> Complete Allergy Medicine Tablets 50mg [Diphenhydramine HCL] |
| <input type="checkbox"/> Acetaminophen Tablets 500 mg | <input type="checkbox"/> Chlor Trimeton 4-hour Antihistamine [Chlorpheniramine Maleate] |
| <input type="checkbox"/> Acetaminophen Tablets 325 mg | <input type="checkbox"/> Cough Suppressant Drops-Cherry |
| <input type="checkbox"/> Acetaminophen Children's Chewable 80 mg | <input type="checkbox"/> Guaiaatussin DM Liquid (non-alcohol) (cough suppressant) |
| <input type="checkbox"/> Anti-Diarrheal Tablets [Loperamide Hydrochloride 2 mg] | <input type="checkbox"/> Ibuprofen Tablets 200 mg (pain relief) |
| <input type="checkbox"/> Bismuth Tablets (indigestion / diarrhea) | <input type="checkbox"/> Pepto Bismol Tablet [bismuth subsalicylate] |
| <input type="checkbox"/> Benadryl Tablets 25 mg (bug bite/poison ivy reactions) | <input type="checkbox"/> Pepto Bismol Liquid [bismuth subsalicylate] |
| <input type="checkbox"/> Benadryl Tablets 50 mg (bug bite/poison ivy reactions) | <input type="checkbox"/> Pseudoval - Nasal Decongestant [Pseudoephedrine HCL 30mg] |
| <input type="checkbox"/> Benadryl Childrens Liquid (no alcohol) [Diphenhydramine HCL] | <input type="checkbox"/> Senna Tablets (natural laxative) |
| (allergy relief) | <input type="checkbox"/> Sepasoothe Lozenge (anesthetic throat lozenge) |
| <input type="checkbox"/> Chloraseptic Throat Spray (sore throat relief) | <input type="checkbox"/> Tums (indigestion) [calcium carbonate] |
| <input type="checkbox"/> Complete Allergy Medicine Tablets 25mg | |

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: _____

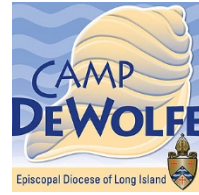
GENERAL QUESTIONS (Explain 'YES' answers below or on separate sheet)

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

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



CAMP DeWOLFE 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:

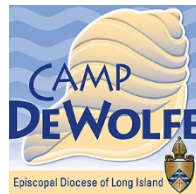
- The Camp DeWolfe staff will make every effort to insure that medical personnel are given my child’s health insurance information at the time of treatment when I have provided copies of the necessary documents;
- Not all medical treatment facilities will file insurance claims. If this situation occurs 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: _____



CAMP DeWOLFE CAMPER HEALTH HISTORY FORM



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

Height: _____ Weight: _____ B/P: _____ Gross Dental: _____

Please give all dates of immunizations for:

Vaccine: Dates? Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr

DTP _____

TD (Tetanus/Diph) _____

Tetanus _____

Polio _____

MMR _____

Or Measles _____

Or Mumps _____

Or Rubella _____

Haemophilus Infl B _____

Hepatitis B _____

Varicella (chicken pox) _____

___ 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.