

**CAMPER HEALTH HISTORY FORM 1**

*Please Print All Information*

<p>This form must be returned by June 1<sup>st</sup> to Center Day Camp 57 Ashmont St. Portland, ME 04103</p> <p>Questions please call: 207-772-1959</p>	<p>Dates will attend camp: ____/____/____ to ____/____/____ Month Day Year Month Day Year</p> <p>Camper Name: _____ First Name Middle Last</p> <p><input type="checkbox"/> M <input type="checkbox"/> F Birth Date: ____/____/____ Age on arrival at camp _____ Month Day Year</p> <p>~~~~~</p> <p><u>To Parents(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.</u></p> <ol style="list-style-type: none"> <li>1. Complete <u>pages 1, 2, and 3</u> of this form (FORM 1).</li> <li>2. Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) on <u>page 4</u> and provide <u>FORM 1</u> with <u>FORM 2</u> to your <u>child's health-care provider</u> for review and completion.</li> <li>3. After it has been <u>completed and signed</u> by your child's health care provider, return FORM 1 and Form 2 to camp by June 1<sup>st</sup>, 2010.</li> </ol>
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Camper Home Address: \_\_\_\_\_  
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name _____	Relationship to Camper _____	Preferred Phones (____) _____
Email _____		(____) _____

Home Address \_\_\_\_\_  
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name _____	Relationship to Camper _____	Preferred Phones (____) _____
Email _____		(____) _____

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name _____	Relationship to Camper _____	Preferred Phones (____) _____
Email _____		(____) _____

**Allergies:**  No known allergies  This camper is allergic to  Food  Medicine  The environment (insect stings, hay fever, etc.)  Other  
**(Please describe below what the camper is allergic to and the reaction seen)**

**Diet, Nutrition:**  This camper eats a regular diet  This camper eats a regular vegetarian diet.  
 This camper has special food needs **(Please describe below - attach additional information if necessary)**

**Restrictions:**  I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.  
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. **(Please describe below)**

**Medical Insurance Information:**  
This camper is covered by family medical/hospital insurance  Yes  No  
**Include a copy of your insurance care if appropriate; copy both sides of the card so information is readable.**

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Insurance Company Phone Number: (\_\_\_\_) \_\_\_\_\_

**Parent/Guardian Authorization for Health Care:**  
This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature or Custodial Parent/Guardian Date Relationship to Camper

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

<b>CAMPER HEALTH HISTORY FORM 1</b>		Camper Name _____																																																																																		
Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses		Birth Date _____ <small>First Middle Last</small> _____/_____/_____ <small>Month Day Year</small>																																																																																		
<b>Immunization History:</b> Provide the month & year for immunizations. Starred (*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.																																																																																				
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Immunization</th> <th style="width: 10%;">Dose 1 Month/Year</th> <th style="width: 10%;">Dose 2 Month/Year</th> <th style="width: 10%;">Dose 3 Month/Year</th> <th style="width: 10%;">Dose 4 Month/Year</th> <th style="width: 10%;">Dose 5 Month/Year</th> <th style="width: 10%;">Most Recent Dose Month/Year</th> </tr> </thead> <tbody> <tr> <td>Diphtheria, tetanus, pertussis * (DTaP) or TdaP)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Tetanus booster * (dT) or (TdaP)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mumps, measles, rubella * (MMR)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Polio * (IPV)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Haemophilus influenzae type B (HIB)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Pneumococcal (PCB)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hepatitis B</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hepatitis A</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Varicella (chicken pox)</td> <td colspan="2"> <input type="checkbox"/> Had chicken pox                      Date: _____                 </td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Meningococcal meningitis (MCV4)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year	Diphtheria, tetanus, pertussis * (DTaP) or TdaP)							Tetanus booster * (dT) or (TdaP)							Mumps, measles, rubella * (MMR)							Polio * (IPV)							Haemophilus influenzae type B (HIB)							Pneumococcal (PCB)							Hepatitis B							Hepatitis A							Varicella (chicken pox)	<input type="checkbox"/> Had chicken pox Date: _____						Meningococcal meningitis (MCV4)							<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Tuberculosis (TB) test</td> <td style="width: 20%;">Date: _____</td> <td style="width: 20%;"><input type="checkbox"/> Negative</td> <td style="width: 30%;"><input type="checkbox"/> Positive</td> </tr> </table>			Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
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If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.																																																																																				
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<b>Medication:</b> <input type="checkbox"/> This camper will not take any daily medications while attending camp. <input type="checkbox"/> This camper will take the following daily medication(s) while at camp. "Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.																																																																																				
Name of Medication	Date Started?	Reason for Taking It	When it is given	Amount or dose given	How it is given																																																																															
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The following non-prescription medications may be stocked in the camp Health Center and are used on an <u>as needed basis</u> to manage illness and injury. <b>Cross out those the camper should <u>not</u> be given.</b>																																																																																				
Acetaminophen (Tylenol) Aloe Antibiotic cream, topical Antihistamine/allergy medicine Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) Calamine lotion Chlorpheniramine maleate Dextromethorphan cough syrup (Robitussin DM) Diphenhydramine antihistamine/allergy medicine (Benadryl) Epinephrine Generic cough drops	Guaifenesin cough syrup (Robitussin) Hydrocortisone Cream Ibuprophen (Advil, Motrin) Ivy Dry Laxatives for constipation (Ex-Lax) Lice shampoo or cream (Nix or Elimite) Phenylephrine decongestant (Sudafed PE) Pseudoephedrine decongestant (Sudafed) Silver Sulfadiazine Sore throat spray Tolnaftate																																																																																			



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<p>The following non-prescription medications are commonly stocked in our camp's Health Center and will be used on an <u>as needed</u> basis to manage illness and/or injury.</p> <p><b>Medical personnel:</b> <b>CROSS OUT</b> those items the camper should <u>not</u> be given...</p> <p>Acetaminophen (Tylenol) Aloe Antibiotic cream, topical Antihistamine/allergy medicine Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) Calamine lotion Chlorpheniramine maleate Dextromethorphan cough syrup (Robitussin DM) Diphenhydramine antihistamine/allergy medicine (Benadryl) Epinephrine Generic cough drops Guaifenesin cough syrup (Robitussin) Hydrocortisone Cream Ibuprophen (Advil, Motrin) Ivy Dry Laxatives for constipation (Ex-Lax) Lice shampoo or cream (Nix or Elimite) Phenylephrine decongestant (Sudafed PE) Pseudoephedrine decongestant (Sudafed) Silver Sulfadiazine Sore throat spray Tolnaftate</p>	<p><b>Physical exam done today:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, date of last physical ____/____/____) Month Day Year ACA accreditation standards specify physical exam within last 24 months.</p> <p>Weight ____ lbs Height ____ ft ____ in Blood Pressure ____/____</p> <p><b>Allergies:</b> <input type="checkbox"/> No known allergies <input type="checkbox"/> Food (<i>list</i>) <input type="checkbox"/> Medicine (<i>list</i>) <input type="checkbox"/> The environment (insect stings, hay fever, etc.) (<i>list</i>) <input type="checkbox"/> Other (<i>list</i>)</p> <p><b>Describe previous reactions:</b></p> <p>_____ _____</p> <p><b>Diet, Nutrition:</b> <input type="checkbox"/> This camper eats a regular diet <input type="checkbox"/> Has a medically prescribed meal plan or dietary restrictions: (<i>describe below</i>)</p> <p>_____ _____</p> <p><b>This camper is undergoing treatment at this time for the following conditions: (<i>describe below</i>).</b> <input type="checkbox"/> None</p> <p>_____ _____</p> <p><b>Medication:</b> <input type="checkbox"/> No daily medications <input type="checkbox"/> Will take the following prescribed daily medication(s) while at camp. (<i>name, dose, frequency - describe below</i>)</p> <p>_____ _____</p> <p><b>Other treatments/therapies to be continued at camp: (<i>describe below</i>)</b> <input type="checkbox"/> None needed</p>
<p><b>Do you feel that the camper will require limitations or restrictions to activity while at camp?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If you answered "Yes" to the question above, what do you recommend? (<i>describe below - attach additional information if needed</i>)</p> <p>_____ _____ _____</p>	
<p>"I have reviewed the CAMPER HEALTH HISTORY FORMS (FORM 1), 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).</p>	
<p>Name of licensed provider (please print): _____ Signature _____ Title _____</p> <p>Office Address _____ Street Address City State Zip Code Telephone (____) _____ Date ____/____/____</p>	