

HEALTH HISTORY FORM FOR CHILDREN, YOUTH AND ADULTS ATTENDING CAMP

Dates of Camp Attendance _____ This form must be completed by June 20 and sent to:
YOUNG PEOPLE'S DAY CAMP, C/O Brenden McCaffrey, 10 Second Avenue, East Islip, New York 11730

The information on this form is not part of the camper/staff acceptance process. It is solely 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 is aware of your needs.

INSTRUCTIONS: PLEASE FILL OUT THIS FORM COMPLETELY. (BOTH SIDES). YOU MUST SIGN SECTIONS 3, 5 AND 9 IN ORDER TO ATTEND CAMP.

1 **Camper/Counselor Name** _____ Birth date _____ Age as of July 1 _____
Last First Middle

Home address _____

Social Security number of participant _____ Gender: Male Female

Custodial parent/guardian _____ Phone _____

Home address _____
(If different from above) Street address City State Zip

Business address _____ Phone _____
Street address City State Zip

Second parent/guardian/ or emergency contact _____

Address _____ Phone _____
Street address City State Zip

Business address _____ Phone _____

If not available in an emergency, notify _____

Relationship _____ Phone _____

Address _____
Street address City State Zip

2 **INSURANCE INFORMATION**

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____

Carrier address _____

Name of insured _____ Relationship to participant _____

Social security number of policy holder or insurance ID number _____

ATTENTION Important - These boxes must be complete for attendance* ATTENTION

*** 3** **Permission to Provide Necessary Medical Treatment or Emergency Care:**
 I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/ or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization for the person named above. This completed form may be photocopied for trips outside the camp.

Signature of parent/guardian/or counselor: x _____
 Witness: _____ Date: _____

I also understand and agree to abide by the restrictions placed on my camp activities.

Signature of minor or adult camper/staffer: x _____ Date _____

I consent to have my child _____ use sunscreen s/he has brought or the camp has supplied, which is approved by the FDA for over the counter use to avoid overexposure to the sun. My child may be assisted by unlicensed camp staff if s/he requests.

Signature: x _____ Date _____

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

4 **ALLERGIES** List all known. Describe reaction and management of the reaction.

Medication allergies (list) _____

Food allergies (list) _____

Other allergies (list) _____

5 I do () do not () give permission for my child to be photographed and the photographs to be displayed at the camp or on camp documents.

Parents Signature x _____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. 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. **Check A or B**

A. This person takes NO medications on a routine basis OR **B.** This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____
 Med #2 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____

Attach additional pages for more medications. Identify any medications taken during the school year that participant does/may not take during summer:

RESTRICTIONS (The following restrictions apply to this individual.)

Does not eat: Red meat Pork Dairy products Poultry Seafood Eggs Other (describe) _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) _____

GENERAL QUESTIONS Check yes or no - explain "yes" answers below

Has/does the participant:	YES	NO		YES	NO
1. Had any recent injury, illness or infectious disease?.....	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness.condition?.....	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp? ..	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?.....	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	29. Does your child have an Epi-Pen?.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>	30. If yes, where will it be kept during camps hours? ...	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			
16. Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>			

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

IMMUNIZATIONS

Which of the following has the participant had?

Measles
 Chicken pox
 German measles
 Mumps
 Hepatitis

TB Mantoux Test
 Date of last test _____
 Result: Positive Negative

IMMUNIZATIONS

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____	_____
or Measles	_____	_____	_____	_____	_____	_____	_____
or Mumps	_____	_____	_____	_____	_____	_____	_____
or Rubella	_____	_____	_____	_____	_____	_____	_____
Haemophilus influenza B	_____	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____	_____	_____
BCG	_____	_____	_____	_____	_____	_____	_____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware. _____

Signature of family physician _____ Date _____ Phone _____
 Address _____
 Name of family dentist/orthodontist _____ Phone _____
 Address _____

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

Signed _____ Printed _____ Date _____

Remember: You **MUST** sign sections 3, 5, and 9 as per NY State/County regulations. **NO CHILD WILL BE PERMITTED TO ATTEND CAMP WITHOUT A COMPLETED HEALTH FORM ON FILE. NOTE:** If you have a complete, written medical form within 12 months of the day camp ended, 8/21/15, you may eliminate **section 8 only.**