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 ______________________

* 3

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

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 ______________________

6

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 ________

____

7

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

Has/does the participant:

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

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

____

____

8

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	____	____					
Haemophilius 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 ____________

9

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.***