

CAMP MOVAL HEALTH FORM 2020

Camper's Name: _____ Dates at Camp _____ Session _____

Home Phone: (____) _____ Date of Birth: _____ Age: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Camper lives with (check one): _____ Both Parents _____ Mother _____ Father _____ Other: _____

Parent/Guardian #1: _____ Parent/Guardian #2: _____

Best Phone: (____) _____ Best Phone: (____) _____

Emergency Contacts (to be used if we are unable to reach parents)

Name: _____ Relationship: _____ Phone(____) _____

Name: _____ Relationship: _____ Phone(____) _____

Name of Physician: _____ Phone(____) _____

Name of Dentist/Orthodontist _____ Phone(____) _____

Family Medical/Hospital Insurance: Carrier: _____ Policy or Group# _____

Dental Insurance Carrier: _____ Policy or Group# _____

*******INCLUDE A COPY OF ALL INSURANCE CARDS WITH THIS FORM*******

Immunization History: Provide the month and year for each immunization. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

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 (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken Pox) Had Chicken Pox <input type="checkbox"/> Date: _____						
Meningococcal meningitis						

Tuberculosis (TB) Test Date: _____ Negative Positive

THIS HEALTH FORM 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 the physician 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 OF PARENT/LEGAL GUARDIAN

OR ADULT CAMPER/STAFF MEMBER: _____ **DATE** _____

WITNESS _____ **DATE** _____

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

SIGNATURE OF CAMPER/STAFFER _____ **DATE** _____

NAME OF CAMPER: _____ **Date of last Physical Exam:** _____

HEALTH HISTORY: _____ **Camper's current weight:** _____

Health History Check "Yes" or "No" for each statement. Explain "Yes" answers below.

- 1. Ever been hospitalized? Yes No
- 2. Ever had surgery? Yes No
- 3. Have recurrent/chronic illnesses? Yes No
- 4. Had a recent infectious disease? Yes No
- 5. Had a recent injury? Yes No
- 6. Asthma/wheezing/shortness of breath Yes No
- 7. Heart disease/defect Yes No
- 8. Frequent ear infection Yes No
- 9. Bleeding/clotting disorders Yes No
- 10. High blood pressure Yes No
- 11. Diabetes Yes No
- 12. Seizures Yes No
- 13. Headaches Yes No
- 14. Wears glasses, contacts or eyewear Yes No
- 15. Fainting or dizziness Yes No
- 16. Passed out/had chest pain during exercise Yes No
- 17. Mononucleosis Yes No

- 18. Back/joint problems Yes No
- 19. Problems with diarrhea/constipation Yes No
- 20. Skin problems Yes No

Mental/Emotional/Social Health

- 21. ADD/ADHD Yes No
- 22. Anxiety/Depression Yes No
- 23. Bipolar Yes No
- 24. OCD Yes No
- 25. Eating Disorder Yes No
- 26. Sleepwalking/falling asleep Yes No
- 27. Bedwetting Yes No
- 28. Fear of storms Yes No
- 29. Fear of the dark Yes No
- 30. Emotional/Behavioral difficulties Yes No
- 31. Other mental health diagnosis Yes No
- 32. Learning disabilities Yes No

Explain any Yes answered questions: _____

Allergies: No Known Allergies Food Medication Insects Environment Other _____

Please specify each allergy and reaction: _____

Diet/Nutrition: Regular Diet Diabetic Vegetarian Lactose Intolerant Gluten Free Other _____

Please Explain: _____

Restrictions: Camper Can Participate in all Programs Camper Has Restrictions (List) _____

Females: Has she menstruated? Yes No If not, has she been told about it? Yes No Are there any problems we need to be aware of? _____

MEDICATION: List all medications camper has taken in the past six months and all medications that will accompany him/her to camp (include over the counter medications and vitamins). Use additional form if necessary. *Please bring all medications in original packaging including name and how to be given.*

Name of Medication	Date Started	Reason for Taking	When it is Given	Amount of Dose	How it is Given
			Breakfast Lunch Dinner Other		
			Breakfast Lunch Dinner Other		

The following non-prescription medications may be stocked in the camp health center and used on an *as needed basis* to illness or injury. Please cross out *those that cannot be given*.

- | | |
|--|---|
| Acetaminophen (Tylenol) | Ibuprofen (Advil, Motrin) |
| Phenylephrine decongestant (Sudafed PE) | Guaifenesin cough syrup (Robitussin) |
| Diphenhydramine Antihistamine (Benadryl) | Dextromethorphan cough syrup (Robitussin DM) |
| Sore throat spray | Generic cough drops/throat drops |
| Lidocaine (topical for sunburns/stings) | Antibiotic cream |
| Lice shampoo or cream (Nix or Elimite) | Aloe |
| Calamine lotion | Hydrocortisone (topical) |
| Laxatives for constipation (Ex-Lax) | Bismuth subsalicylate for diarrhea (Pepto-Bismol) |
| Tums | Gatorade/Pedialyte |

Any other information to ensure that your camper can have the best outdoor experience? _____

CAMP MOVAL DOCTOR FORM

Dates will attend camp: from _____ to _____

To Parent(s)/Guardian(s): Complete this section and give *this form* and a copy of your completed CAMPER HEALTH HISTORY FORM to your child's health-care provider for review.

Camper Name: _____

Male Female Birth Date ____/____/____ Age on arrival at camp _____

Camper home address: _____

Custodial parent(s)/guardian(s) phone: (_____) _____ (_____) _____

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. **Medical personnel: Check those items the camper can be given.**

- | | |
|---|--|
| <input type="checkbox"/> Acetaminophen (Tylenol) | <input type="checkbox"/> Ibuprofen (Advil, Motrin) |
| <input type="checkbox"/> Phenylephrine decongestant (Sudafed PE) | <input type="checkbox"/> Guaifenesin cough syrup (Robitussin) |
| <input type="checkbox"/> Diphenhydramine Antihistamine (Benadryl) | <input type="checkbox"/> Dextromethorphan cough syrup (Robitussin DM) |
| <input type="checkbox"/> Sore throat spray | <input type="checkbox"/> Generic cough drops/throat drops |
| <input type="checkbox"/> Lidocaine (topical for sunburns/stings) | <input type="checkbox"/> Antibiotic cream |
| <input type="checkbox"/> Lice shampoo or cream (Nix or Elimate) | <input type="checkbox"/> Aloe |
| <input type="checkbox"/> Calamine lotion | <input type="checkbox"/> Hydrocortisone (topical) |
| <input type="checkbox"/> Laxatives for constipation (Ex-Lax) | <input type="checkbox"/> Bismuth subsalicylate for diarrhea (Pepto-Bismol) |
| <input type="checkbox"/> Tums | <input type="checkbox"/> Gatorade/Pedialyte |

Physical exam done today: Yes No (If "No," date of last physical: ____/____/____) Weight: _____ lbs Height: ____ft ____in Blood Pressure ____/____

ACA accreditation standards specify physical exam within last 12 months.

Allergies: No Known Allergies

To foods (**list**):

To medications: (**list**):

To the environment (**insect stings, hay fever, etc. - list**): Other allergies: (**list**):

Describe previous reactions:

Diet, Nutrition: Eats a regular diet. Has a medically prescribed meal plan or dietary restrictions: (**describe below**)

The camper is undergoing treatment at this time for the following conditions: (describe below**)** None.

Medication: No daily medications. Will take the following prescribed medication(s) while at camp: (**name, dose, frequency—describe on Medication Form**).

Other treatments/therapies to be continued at camp: (describe below**)** None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? No Yes

"I have reviewed the CAMPER HEALTH HISTORY FORM (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.)"

Name of licensed provider (please print): _____

Signature: _____

Office Address: _____

Telephone: (_____) _____ Date: _____

Camper Name: _____ Date Of Birth: _____

Allergies: _____

Medication Name	Date Started	Reason for Taking	When It Is Given	Dosage	How It Is Given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		