Camp Sandy Cove

HEALTH HISTORY FORM

Summer Address:
RT 1 Box 471
High View, WV 26808
Phone: (304) 856-2959
Fax: (304) 856-1683

Corporate Address:
60 Sandy Cove Rd
North East, MD 21901
Phone: (410) 287-5433
Fax: (410) 287-3196

PLEASE BRING COMPLETED HEALTH FORM, INCLUDING DOCTOR'S PHYSICAL & IMMUNIZATIONS (OR RELIGOUS EXEMPTION) WHEN YOU BRING YOUR CHILD TO CAMP

Camper Name ______________________ Birth Date ___/___/___ Sex ☐M ☐F Age _____
Last First Initial

Parent/Guardian ______________________ Phone ______________________
Area Code & Number

Home Address ______________________
Street & Number City State Zip

Business Phone ______________________ Cell Phone ______________________
Area Code & Number Area Code & Number

2nd Parent/Guardian if applicable ______________________

Home Address ______________________ Phone ______________________
Street & Number City State Zip Area Code & Number

Business Phone ______________________ Cell Phone ______________________
Area Code & Number Area Code & Number

Emergency Contact's Name & Relationship: ______________________
Contact this person if parents cannot be reached

Home Phone ______________________ Cell Phone ______________________

ALLERGIES

___ Hay Fever
___ Ivy Poisoning
___ Insect Stings
___ Food Allergies
____
____
___ Drug Allergies
____
____

Please select the dates your child will be attending:

___6/1-6/3/2012 ___6/24-7/1/2012 ___7/1-7/8/2012 ___7/8-7/15/2012

___7/15-7/22/2012 ___7/22-7/29/2012 ___7/29-8/5/2012 ___8/5-8/12/2012

Name of family physician ______________________
Phone ______________________ Fax ______________________
Name of dentist/orthodontist ______________________
Phone ______________________ Fax ______________________

MEDICAL INSURANCE INFORMATION

I understand that my insurance carrier is responsible for bills incurred by my child. If my child is not covered by an insurance policy, or I fail to provide the necessary information, I am responsible.

Camper is covered by family medical/hospital insurance ☐ Yes ☐ No
Please supply a copy of your insurance card.

Insurance Company: ______________________ Insurance Company Phone Number: ______________________
Policy Number: ______________________
Subscriber: ______________________ Policy Holder's Date of Birth: ______________________
Name of Policy Holder

PARENT AUTHORIZATION FOR HEALTH CARE

IMPORTANT - This box must be completed by parent/guradian if camper is to attend camp

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for my child. In the event 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 my child as named above. The completed forms may be photocopied for trips out of camp. 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 or guardian or staff member ______________________ Date ______________________

Relationship to camper: ______________________

Camper Name ______________________________ Birth Date ___/___/___
Last First Initial

IMMUNIZATION HISTORY

Please record the date (month and year) of basic immunizations and most recent booster doses. Or attach a religous exemption.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diptheria Pertussis (Whooping Cough) **DPT*** Tetnus Or	1. 2. 3.	1. 2.
Tetnus Diptheria **TD***		
Polio (IPV)		
Measles, Mumps, Ruebella (MMR)		
Varicella/Chicken Pox (if had/give date)		
Hepatitis B		
Tuberculin test given (most recent)		
Haemophilus influenza b (HIB)		
Meningococcal Meningitis (MCV4)		

GENERAL HEALTH HISTORY

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

Has/does the camper:

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. Had asthma/wheezing?............................ __Yes __No
7. Have diabetes? .... __Yes __No
8. Had seizures? .... __Yes __No
9. Had headaches? .... __Yes __No
10. Wear glasses or contacts? .... __Yes __No
11. Ever been treated for ADD/ADHD? .... __Yes __No
12. Ever been treated for emotional/behavioral difficulties? .... __Yes __No
13. Had fainting or dizziness? .... __Yes __No
14. Passed out/had chest pain during exercise? .... __Yes __No
15. Had mononucleosis ("mono") during the past 12 months?......... __Yes __No
16. If female, have problems with periods/menstruation?............... __Yes __No
17. Have problems with falling asleep/sleepwalking? .... __Yes __No
18. Ever had back/joint problems?.. __Yes __No
19. Have a history of bedwetting?... __Yes __No
20. Have problems with diarrhea/constipation?.............................. __Yes __No
21. Have any skin problems?.. __Yes __No
22. Traveled outside the country in the past 9 months?.................... __Yes __No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel. ____

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MEDICATION

☐ **This camper will not take any medication while at camp.**

☐ **This camper will take the following daily medication(s) at camp.**

We require original pharmacy containers with labels which show the camper's name and how the medication should be given.
Please provide enough medication to last the entire time the camper is at camp.

Name of Medication	When it is given	Amount or dose given	How it is given
	☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime		
	☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime		
	☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime		

Camper Name ______________________________ Birth Date ___/___/___
Last First Initial

TO BE COMPLETED BY A LICENSED PHYSICIAN

I have examined the above camper/staffer within the past year. Date Examined: ______________

Height: ________________ Weight: ________________ Blood Pressure: ______________

The camper/staffer is under the care of a physician for the following condition(s): ____________________

Current Treatment (include medications): ____________________

Treatment to be continued at camp: ____________________

Does the camper/staffer have epilepsy? ☐ Yes ☐ No Does the camper/staff member have diabetes? ☐ Yes ☐ No

Medications to be administered at camp (specific dosages): ____________________

Medically prescribed meal plan or dietary restrictions (where possible): ____________________

Allergies (food, drug, plants, insects, etc.): ____________________

Any restrictions or limitations on specific activities (specify): ____________________

Do you feel that the camper/staff member will require limitations or restrictions while at camp? ☐ Yes ☐ No

Licensed Physician's Signature: ____________________

Licensed Physician's Printed Name: ____________________

Address: ____________________ Phone: ______________
Street & Number City State Zip Area Code/Number

Date of Form Completion: ______________ By: ______________
Indicate completed by a nurse or physician's assistant.