# Camp Sandy Cove

Camper

## HEALTH HISTORY FORM

**Summer Address:**
436 Reflection Ln
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 COMPLETE THIS FORM, INCLUDING IMMUNIZATIONS (OR RELIGIOUS EXEMPTION) AND BRING IT TO CAMP WITH YOUR CHILD**

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

☐ No known allergies
☐ Medicine allergies
☐ Food allergies
☐ Environment allergies

Please describe all that the camper is allergic to and the reaction seen.

_____
_____
_____
_____

Please select the dates your child will be attending:

___6/24-7/1/2018 ___7/1-7/8/2018 ___7/8-7/15/2018

___7/15-7/22/2018 ___7/22-7/29/2018 ___7/29-8/5/2018 ___8/5-8/12/2018

Name of family physician _____

Phone _____ Fax _____

Name of dentist/orthodontist _____

Phone _____ Fax _____

### MEDICAL INSURANCE INFORMATION

If my child is not covered by an insurance policy, or I fail to provide the necessary information, I am financially responsible.

Camper is covered by medical/hospital insurance ☐ Yes ☐ No

**Please supply a copy of your insurance card.**

Insurance Company: _____ Insurance Company Phone Number: _____
Policy Number: _____ Group 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 _____ Date _____

Relationship to camper: _____

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

# IMMUNIZATION HISTORY

The following verifies that all immunizations required for attending school are up to date.
Please record the date (month and year) of basic immunizations and most recent booster doses. Or attach a signed religious exemption.

| Vaccines | Year of Basic Immunization | Year of Last Booster |
|---|---|---|
| Diptheria<br>Pertussis (Whooping Cough)<br>Tetnus<br>Or | 1.<br>2.<br>3. | 1.<br>2.<br>3. |
| Tetnus booster | | |
| Polio (IPV) | | |
| Measles, Mumps, Ruebella (MMR) | | |
| Varicella/Chicken Pox (if had/give date) | | |
| Hepatitis B | | |
| Hepatits A | | |
| Tuberculosis test (most recent) Date: ____/____/____ | ☐ Negative ☐ Positive | |
| 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. _____

_____

_____

# 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<br>☐ Lunch<br>☐ Dinner<br>☐ Bedtime | | |
| | ☐ Breakfast<br>☐ Lunch<br>☐ Dinner<br>☐ Bedtime | | |
| | ☐ Breakfast<br>☐ Lunch<br>☐ Dinner<br>☐ Bedtime | | |

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

## TO BE COMPLETED BY THE PARENT OR GUARDIAN

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

_____

_____

Current Treatment (include medications): _____

_____

_____

_____

Treatment to be continued at camp: _____

_____

_____

_____

Medically prescribed meal plan or dietary restrictions: _____

_____

_____

_____

_____

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

Please list restrictions or limitations on specific activities (specify): _____

_____

_____

_____

**What have we forgotten to ask?** Please provide any additional information about the camper's health that you think is important or that may impact the campers ability to fully participate in the camp program. (Attach additional information if needed.)

**Do you have important questions or comments for our nurse? Feel free to email her at:**
**campnurse@sandycove.org**

Parent or Guardian Signature: _____

Parent or Guardian Printed Name: _____

Date of Form Completion: _____