

# CAMP HEALTH FORM

**PLEASE ATTACH A RECENT PHOTO**

Mail this form to the address below by May 1st.

**CAMP OFFICE**  
1528 Walnut Street, Suite 1900  
Philadelphia, PA 19102

Dates will attend camp: from \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Camper Name: \_\_\_\_\_  
First Middle Last

Male  Female Birth Date \_\_\_\_\_ Age on arrival at camp: \_\_\_\_\_  
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

- 1) Complete page 1, 2 and 3 of this form to be completed by parents.
- 2) Annual physical required.
- 3) Last page to be completed by licensed medical personal.
- 4) Make a copy for your records & return original form to camp office with photo & insurance info.

Camper Home Address: \_\_\_\_\_  
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Allergies:  No known allergies.  This camper is allergic to:  Food  Medicine  The environment (insect stings, hay fever, etc.)  Other  
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition:  This camper eats a regular diet.  This camper eats a regular vegetarian diet.  
 This camper has special food needs. (Please describe below.)

Restrictions:  I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.  
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. (Please describe below.)

**Medical Insurance Information:**

This camper is covered by family medical/hospital insurance  Yes  No

**Include a copy of your insurance card; copy both sides of the card so information is readable.**

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
Subscriber \_\_\_\_\_ Insurance Company Phone Number (\_\_\_\_\_) \_\_\_\_\_

**Parent/Guardian Authorization for Health Care:**

I, on behalf of my child (or for adult staff, on behalf of myself) certify to camp that I have provided a full and complete disclosure of all medical, psychological or emotional conditions, including medications that are being taken and/or withheld during the time my child is (I am) at camp.

This health history 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 Custodial Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Camper Name

First

Middle

Last

(For Camp Use) Cabin or Group

(For Camp Use) Session Code(s):

# CAMP HEALTH FORM

**Immunization History:** Provide the month and year for each immunization. Starred (★) immunizations must be current. 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)	<input type="checkbox"/> Had chicken pox <input type="checkbox"/> Date: _____					
Meningococcal meningitis (MCV4)						
H1N1 Vaccine						

Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
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*If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.*

Signature of Custodial Parent/Guardian: _____	Date: _____	Relationship to Camper: _____
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- Medication:**  This camper will not take any daily medications while attending camp.  
 This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

- |  |   |
|--|---|
| Acetaminophen (Tylenol)<br>Phenylephrine decongestant (Sudafed PE)<br>Antihistamine/allergy medicine<br>Diphenhydramine antihistamine/allergy medicine (Benadryl)<br>Sore throat spray<br>Lice shampoo or cream (Nix or Elimite)<br>Calamine lotion<br>Laxatives for constipation (Ex-Lax) | Ibuprofen (Advil, Motrin)<br>Pseudoephedrine decongestant (Sudafed)<br>Guaifenesin cough syrup (Robitussin)<br>Dextromethorphan cough syrup (Robitussin DM)<br>Generic cough drops<br>Antibiotic cream<br>Aloe<br>Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |
|--|---|

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

Has/does the camper:

- |   |   |
|---|---|
| 1. Ever been hospitalized? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   | 11. Had fainting or dizziness? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         |
| 2. Ever had surgery? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         | 12. Passed out/had chest pain during exercise? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| 3. Have recurrent/chronic illnesses? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No         | 13. Had mononucleosis ("mono") during the past 12 months?... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No          | 14. If female, have problems with periods/menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                      | 15. Have problems with falling asleep/sleepwalking? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| 6. Had asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 16. Ever had back/joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| 7. Have diabetes? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                            | 17. Have a history of bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| 8. Had seizures? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             | 18. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| 9. Had headaches? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                            | 19. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             |
| 10. Wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> 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.*

**Mental, Emotional, and Social Health:** Check "Yes" or "No" for each statement.

Has the camper:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? .....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect the camper's life?.....<br>(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

*Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.*

**Health-Care Providers:**

Name of camper's primary doctor(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Name of dentist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Name of orthodontist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**What Have We Forgotten to Ask?** *Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.*

**Please furnish credit card information in the space below to allow the purchase of medicine, if needed, from the local pharmacy and to pay for any doctor appointments for your child. No appointments will be scheduled and no medication will be administered without your notification, but this information will allow the acquisition of medication without delay.**

Card Type  MasterCard  Visa # \_\_\_\_\_

Name on Card: \_\_\_\_\_

Security Code: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

**Note: All medical and confidential information is kept in a secure location.**

# This Page to be Completed by Licensed Medical Person

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:** *Cross out those items the camper should not be given.*

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Chlorpheniramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimite)
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

**To Parent(s)/Guardian(s):** Complete this section and give this form to your child's health-care provider for completion

Dates will attend camp: from \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year                      Month/Day/Year

Camper Name: \_\_\_\_\_  
First    Middle    Last

Male    Female      Birth Date \_\_\_\_\_      Age on arrival at camp \_\_\_\_\_  
Month/Day/Year

Camper home address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Custodial parent(s)/guardian(s) phone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

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

**Medical Personnel:** Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

**Physical exam done today:**  Yes  No (If "No," date of last physical: \_\_\_\_\_)  
Month/Day/Year

ACA accreditation standards specify physical exam.

Weight: \_\_\_\_\_ lbs   Height: \_\_\_\_\_ ft \_\_\_\_\_ in   Blood Pressure \_\_\_\_\_ / \_\_\_\_\_

**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 below*)

**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

*If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)*

"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: \_\_\_\_\_ Title: \_\_\_\_\_

Office Address \_\_\_\_\_  
Street    City    State    Zip Code

Telephone: (\_\_\_\_) \_\_\_\_\_      Date: \_\_\_\_\_

Camper Name

First

Middle

Last

(For Camp Use) Cabin or Group

(For Camp Use) Session Code(s):